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Pepperdine University  
Graduate School of Education and Psychology

A STUDY OF HEALTH CARE PAYMENT ORGANIZATIONS' CULTURE AND  
ADAPTABILITY TO REVOLUTIONARY CHANGE

A dissertation submitted in partial satisfaction  
of the requirement for the degree of  
Doctor of Education in Organization Change

by

Susan Andree Hunt

April, 2012

Kay Davis, Ed.D. — Dissertation Chairperson

This dissertation, written by

Susan Andree Hunt

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF EDUCATION

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## DEDICATION

I dedicate this study to my father, Thompson A. Moore, who always took care of his family and responsibilities. Through hard work and perseverance he rose to the top of his profession. He never had the opportunity to attend college and strongly believed that a higher education would have made his journey easier and provided greater opportunity. To this day you continue to be an inspiration; thanks for pointing me in the right direction.

## ACKNOWLEDGMENTS

I want to thank my husband, Kevin, for his unfailing support, patience, and love throughout my doctoral journey. I am so lucky to share my life with you! I also want to recognize my daughter, Andree, for taking time away from her family to proof my work; she's truly earned an honorary degree. To my chair, Kay Davis and committee members, your direction and support were invaluable. Finally, a big thank you to family, friends and colleagues who encouraged me along the way and assisted with my research.



## VITA

### SUMMARY

Successfully developed significant business opportunities and managed large project implementations with new and existing clients. Effectively led progressively larger and more complex business operations, including postmerger integration activities and new client implementations. Continuously demonstrated the ability to develop creative solutions to meet emerging business needs. Maintained profit and loss responsibilities as well as revenue forecasting on a department and company-wide basis. Cofounder of a health care consulting practice that develops sales and strategic partnership opportunities for midsize innovators in the health care cost management field.

### WORK HISTORY

#### ***HEB Enterprises, LLC***

*Managing Member—April 2008–Present*

Assist health care cost management organizations in marketing and distributing their products and services by identifying new strategic opportunities and business models. Support the sales activities for our national client base with products that include National and regional provider networks, provider negotiation services, fraud and abuse detection, telephonic medical services, on-site employee clinics, and medical management review. Provide consulting services to develop provider networks, optimize operations, conduct project management, and enhance revenue generation. Support clients in identifying prospects and presenting their services to group health and workers' compensation payers, third-party administrators, union trust funds, associations, and self-funded employer groups. Responsible for HEB Enterprises business management functions and contracting activities.

#### ***Concentra Network Services (CNS)—Viant, Inc.***

*Vice President Account Management Western Region—January 2006–March 2008*

Led account management team of 22 employees managing more than 300 clients. Responsible for revenue projections and for client retention and growth. Assisted staff in identifying and developing business opportunities. Duties included the integration of the Beech Street acquisition into the CNS organization. Responsible for personnel management and expense budget for the Western Region account management unit. Directed large implementations to completion and provided guidance to assure resolution of client issues. Negotiated service and fee agreements with major customers. Provided market intelligence to the organization based on client needs and opportunities. Served as the key contact for clients in the Western Region.

*National Account Executive—June 2004–January 2006*

Responsible for retention and development of West Coast national accounts for major payers and specialty health care companies. Provided direction and prioritized activities for support staff and operational areas as pertains to assigned accounts. Oversaw contract and pricing activities. Maintained relationships with account decision makers to capitalize on new business opportunities. Communicated market needs to the organization in order to maintain a competitive advantage. Forecasted book of business revenue and coordinated activities to assure deliverables were met.

***Safeguard Dental and Vision (acquired Health Net Dental and Vision)***

*Senior Director Group Services—November 2003–May 2004*

Directed operations for the Group Billing & Eligibility, Individual Billing, and Client and Broker Services Departments totaling 60 employees. Responsible for the financial performance, service delivery, and workflow. Functions included maintaining member eligibility, monthly employer billings, reconciliations, collections, contract administration and renewals, as well as providing internal support to groups and brokers and all activities pertaining to individual products. Developed and maintained performance measurements to allow optimal service delivery in a rapidly growing organization. Held a leadership role in corporate initiatives, including IS prioritization, system conversions, business integration, strategic partnerships. Member of the senior management team.

***Health Net Dental and Vision (acquired by Safeguard Dental and Vision)***

*Director Account Management and Premium Accounting—November 2002–November 2003*

Responsible for the overall management of midmarket and large accounts, including retention, growth, and renewal activities. Oversaw customer enrollment and eligibility functions, including electronic transmission of data and manual applications. Directed department activities, budget, and personnel functions. Responsibilities included oversight of staff in Southern and Northern California. Promoted to this position in order to enhance operations and achieve a higher level of customer and employee satisfaction. Continued participation in numerous company committees.

*Director Customer Service—February 2001–November 2002*

Directed operations and activities for the Company's call center. Successfully reorganized the department to achieve significant improvements in productivity and service levels while simultaneously reducing operating costs. Implemented a call monitoring auditing process to assure service excellence. Significantly improved employee morale as measured by the annual associate survey. Assisted in the design, testing, and implementation of the organization's interactive voice response system.

Responsibilities included all budget and personnel management functions, sales department interface, as well as representation on the company's Grievance and Appeals, Quality Management, and HIPAA Committees. Department improvements contributed to client retention rate of 97% for fiscal year 2001.

***ReadyScript, Inc (Start-up company did not obtain funding)***

*Vice President Account Management—March 2000–January 2001*

Instituted the Account Management and Training functions for a start-up business that developed handheld point-of-care technology for physician practices. Conducted alpha meetings with medical groups and physicians to define and document product specifications. Evaluated medical clinic workflows and recommended system solutions to maximize productivity. Acted as the primary customer contact. Developed and maintained an issue tracking system to prioritize issues, promote communication, and assure resolution. Authored training manuals and conducted physician and group practice training. Designed the new client implementation process to assure timely and accurate installation of new client sites. Prepared department strategic plan, including business development forecasting.

***Health Connections, Inc.***

*Executive Director—February 1999–March 2000*

Responsible for all operations, sales support, and account management functions for a national medical call center handling 40,000+ calls per month. Implemented an organizational structure to market effectively and manage rapidly growing operations. Developed project management tools for implementation of new business. Created service standards to monitor and enhance performance. Instituted client management tools that resulted in significant business growth. Managed the customer service, clinical, telecommunications, information systems, and administration staff. Developed financial models and tracking mechanisms for revenue forecasting and budgeting. Acted as the senior contact with the company's leading accounts.

***Beech Street Corporation***

*Vice President Account Management and Customer Service—July 1997–February 1999*

Managed the National Account Management Department responsible for client implementation, retention, and development. Duties included strategic planning for key accounts in order to capitalize on business growth opportunities. Oversaw budget and revenue forecasting as well as provided strategic direction to the company regarding client needs and market priorities. Management duties included personnel-related functions for a staff of more than 100 in eight locations as well as responsibility for call center operations. Prioritized client system interfaces. Successfully stabilized a

deteriorating account management function while achieving a client retention rate of more than 95%.

### ***The Precept Group***

*Senior Vice President Account Management & Operations—October 1996–July 1997*

Managed the operations and client relations for a California-based benefits consulting firm. Responsibilities included staff management as well as implementation of personnel policies and corporate procedures. Developed and maintained client focused measurement tools to assure high levels of satisfaction. Provided medical, dental, vision, life, disability, and 401k plan design recommendations to employers; prepared open enrollment materials; and conducted benefits meetings. Achieved enhanced level of client focus through training and new processes.

### ***Beech Street Corporation—1989–1996***

*Vice President National Contracting*

Responsible for the management and ongoing development of a leading national preferred provider organization composed of 3,000 hospitals, 210,000 physicians, and 7,000 ancillary providers. Managed all business-development activities with the network providers. Successfully led significant projects to meet the company's corporate objectives. Achieved high levels of growth while reducing operating expenses. Effectively converted nondirect provider relationships to direct contracts.

*Vice President Account Management*

Responsible for the company's health benefits and workers compensation account management functions, including client retention and growth, sales support, client reporting, payer education, internal communication/coordination of client initiatives, contract compliance, client satisfaction surveys, and sales initiatives. Clients included *Fortune* 500 companies, third-party administrators, and managed care organizations. Responsible for revenue generation and forecasting on existing business. Served as chairman of the People Development Committee and a member of the Senior Management Team and Information Systems Steering Committee. Achieved a high level of client satisfaction. Successfully managed a rapidly growing department with increased product responsibilities while consistently achieving corporate performance and financial objectives. Significantly contributed to a 200% growth in revenues.

### ***August International***

*Manager Client Services—1986–1989*

Responsible for the development and management of the company's Client Services and Customer Reporting Departments for utilization management and claims administration.

Developed procedures for client implementation and management as well as reports to support contract obligations. Designed employee education materials and assisted in the development of the utilization management software. Client included health benefits and workers compensation organizations in the private and public sectors. The department grew tenfold in 3 years and achieved a client retention rate of 100%.

***Beech Street Corporation***

***Client Service Representative and Manager of New Product Development—1982–1986***

Responsible for client service of designated utilization management and Taft Hartley Trust accounts. Installed new accounts, prepared and presented customer reports, and introduced new products to customers. Developed new procedures for the company's emerging preferred provider organization and assisted with provider contracting, software design, internal training and sales, and provider education collaterals.

**EDUCATION**

2011—Doctoral Candidate—Organization Change—Pepperdine University, Malibu, CA

1982—MBA—Pepperdine University, Malibu, CA

1979—BA—International Relations & French—University of Redlands, Redlands, CA

**CERTIFICATES**

1999—AT&T College of Call Center Excellence

1998—National Account Management, American Management Association

1987—HIAA Certificates A, B, and C

**LANGUAGES**

French—Fluent

Spanish—Basic knowledge

## ABSTRACT

The U.S. health care system is in the midst of revolutionary change. Health care costs continue to rise, significant portions of the population remain uninsured, and government regulation is increasing. The culture of organizations influences their ability to change, and research demonstrates that those with the characteristics of learning organizations are most adaptable. This study sought to establish the characteristics of health care payment organizations and to determine how well these align with the characteristics of learning organizations. A survey was sent to 138 individuals employed by 79 organizations in multiple segments of the industry to obtain their perception of their organizations' cultures. A total of 106 responses were received representing all segments.

This research found that the industry overall does not demonstrate a culture profile that is closely aligned with the characteristics of learning organizations; instead, it showed a distributed culture profile with a marginal emphasis toward the *Market* and *Clan* cultures. The study provides important insight into the characteristics of the industry. Additionally, it indicates that the culture profiles and attributes vary by industry segments within the health care payment industry.

The 1st conclusion is that the industry culture is not well positioned to adapt to revolutionary change. Organizations need to explore their individual culture to understand how they are uniquely positioned to become learning organizations. Second, since certain segments of the industry are better positioned; they provide a model for the rest of the industry to adopt. Third, the industry's culture profile overall shows a competitive, goal-oriented environment, driven by financial results. That focus may not be the best model for successfully adapting to revolutionary change. Finally, the study

confirms that organizational culture is complex and requires in-depth analysis to plan for and adapt to the continuously changing environment.

## **Chapter 1: Purpose of Study**

President Barrack Obama signed the Patient Protection and Affordability Care Act (PPACA), frequently referred to as health care reform on March 23, 2010. According to the House Committees on Ways and Means, Energy and Commerce, and Education and Labor, in its broadest context, the goal of this milestone legislation is to “ensure that all Americans have access to quality, affordable health care and [to] create the transformation within the health care system necessary to contain costs” (as cited in House Committees on Ways and Means, Energy and Commerce, and Education and Labor, 2010, p. 1). This legislation will be phased in throughout the next several years and requires major changes to how health care is currently administered. Some of the significant changes include:

1. Elimination of benefit plan exclusions and coverage limitations.
2. Mandated health care expenditure ratios for medical spending versus administrative spending.
3. Formation of Accountable Health Plans whereby reimbursement is driven by quality of care versus intensity of services.
4. Mandated coverage for most Americans.
5. Formation of health exchanges to provide affordable medical coverage for low income and otherwise uninsured individuals.
6. Government oversight to assure adherence to the law coupled with penalties for noncompliance.

These changes, even though not all are yet implemented, represent a major shift from what has been available. The ongoing national debate surrounding the required



changes within the health care industry demonstrates that to those impacted, the change is considered revolutionary. Burke (2008), in his book explaining the different levels of change faced by organizations and how best to implement these, suggests that it is rare for organizations to be faced with “revolutionary change—a major overhaul of the organization resulting in a modified or entirely new mission, a change in strategy, leadership, and culture” (p. 1). He further indicates that for revolutionary change to occur, “it is very important to understand the various effects of organization change across the primary levels of any social system. These primary levels are the *individual*, the *group* or work unit, and the *total system*” (p. 22) as well as the business unit. Burke also explains that where an organization needs to undergo significant change in response to major shifts in its external environment, it must “change its basic strategy...its mission statement, the organization’s *raison d’être*” (p. 22). He states that for these changes to be successful, the organization’s culture must be modified. Likewise Beckhard and Pritchard (1992) indicate change in culture is a critical component to achieving organizational change.

Considering the sweeping changes resulting from the health care reform legislation, organizations that support the administration of health care services will need to make revolutionary changes in how they do business to survive in this new environment. At the America’s Health Insurance Plan conference in June 2010, the opening session featured David Cutler, Ph.D., professor of applied economics at Harvard; William Frist, M.D., U.S. Senator from Tennessee; and Donna Shalala, president of University of Miami and former Secretary of the U.S. Department of Health and Human Services. The topic for this session was the impact of health care reform on the insurance

industry. During this session, the panelists warned the audience that adapting to the new environment brought forth by health care reform would require that organizations in this business segment change their culture. Research is needed to understand the type of culture that will enable health care payment organizations to adapt and succeed under health care reform. The literature indicates that organizations that best adapt to a changing environment are learning organizations (Marquardt, 2002; Taylor as cited in Morgan, 2006 ; Senge, 2006). This research attempted to help health care payment organizations determine whether their current culture encompasses the characteristics of learning organizations. Based on these findings, these organizations will obtain a better understanding of how well positioned they are to adapt to their new environment.

### **Problem Statement**

Given the scope of changes required to comply with the PPACA, health care payment organizations are scrambling to understand the requirements, adhere to the mandates and compliance timelines, understand the impact on their business model, and realign strategies and resources to survive in this emerging environment. The health care industry is vast and is composed of those organizations that deliver direct or indirect patient care as well as those that support the industry by providing regulatory oversight, reimbursement, medical device development, pharmaceuticals, technology, etc. One significant segment of the health care industry is the insurance and payment administration component, which supports individual payment reimbursement practices. There are around 1,000 U.S. health insurance companies and hundreds of additional organizations that support other aspects of the payment processes (Association of Health Insurance Plans, 2011; Deutsche Bank Securities Inc., 2010; Hoovers, 2012). Some

companies such as Principal Financial Group, a long-standing insurance company providing health care coverage to companies and individuals, have decided to exit the market instead of trying to adapt to the mandated changes (Principal Financial Group, 2010). Other major insurance companies are warning that premiums will increase to meet the legislative requirements, which call for broader coverage. At the same time, states are pushing back on increased premiums as well as challenging the legality of the legislation. Clearly, the environment has been destabilized and the players in this arena need to change how they operate in order to reallocate both human and financial resources to deal with this new environment. While the PPACA is the driving force behind many of the mandated changes, it is the result of long-standing issues in managing health care costs, accessibility, and quality. The health care payment arena has been rocked by ongoing environmental forces. Therefore, regardless of the outcome of health care reform, it is important for organizations in the health care payment arena to obtain a better understanding of their organizational culture and how it influences their ability to adapt.

Since the November, 2010 midterm national elections, there has been much speculation that some or all of the provisions of the PPACA might be repealed. It is my opinion that with a Democratic Senate and President, the law will stand. However, in an effort to demonstrate a willingness to reach across party lines, I believe we will see the Democrats compromise on some of the implementation requirements. While the specific provisions of the law remain fluid, all indications are that reform will move forth. The lack of clarity presented by the political environment adds further complexity to this already unstable environment. As the exact nature of many of the mandated changes remains uncertain, organizations will not only need to adapt to anticipated changes, but

also be prepared to revise quickly plans to contend with newly negotiated political compromises that change specific requirements.

The literature indicates that for organizations to adapt to revolutionary change, they must first look at whether their organization's cultural DNA will embrace the new way of life or whether it will resist the needed changes. The consensus is that for change programs to be effective, cultural assessments will need to be done to understand which parts of the existing culture can best be utilized to facilitate the changes and which components need to be changed (Buono & Kerber, 2010; Cameron & Quinn, 2006; Schein, 2000). Regardless of the final scope of the health care reform bill, a cultural change in organizations within this business segment will need to occur. Whether this change requires embracing the bill as initially drafted or in a modified version, the corporate culture needs to be adaptable and flexible to meet whatever the new requirements dictate. At present, the implementation schedule runs to 2017, indicating that the environment will remain unstable for many years. In addressing how organizational culture affects the ability for organizations to change, Hatch and Cunliffe (2006) cite a Kotter, Heskett, and Denison study that found "that culture significantly influenced organizational performance when it either helped the organization to anticipate or adapt to environmental change or interfered with its adaptation...when cultures do not support adaptation, cultural strength can interfere with performance" (p. 189). To survive the volatile environment facing them, health care payment organizations must be nimble and able to deal with severe disruption. The first step in surviving these changes is to understand whether their current culture will allow them to handle the

changes ahead or whether they must concurrently change their internal DNA to permit them to meet the challenges they face.

Pritchett (n.d.), in his handbook on changing corporate culture, warns, “Change ruthlessly destroys organizations with cultures that don’t adapt” (p. 2). Sorensen (2002), in his study of how strong cultures enhance organizational performance, states that organizational culture is the result of past learning that influences how organizations deal with future problems. He indicates that faced with a new environment, the existing organizational routines may be inadequate. He then cautions, “Environmental shifts demand learning and modifications in organizational routines that take the new conditions into account. Unless the organization discovers such solutions rapidly, it will perform haphazardly” (p. 74). Schein (2004), in his book on the importance of culture in implementing change in organizations, further supports the concept that organizational culture is the result of past successes. He states:

Culture ultimately reflects the group’s effort to cope and learn; it is a residue of that learning process. Culture thus not only fulfills the function of providing stability, meaning and predictability in the present but is the result of functionally effective decisions in the group’s past. (p. 109)

The new environment presented by health care reform does not represent the status quo and is no longer stable. Therefore, a culture based on prior values and norms may no longer work.

If understanding organizational culture is the foundation to successful change, then the first step for health care payment organizations to adapt, survive, and ideally thrive while fulfilling the honorable premise of health care reform is for the organizations

to understand their own culture. Health care payment organizations that support the health care payment system are critical to the reform process. In fact, within the industry, PPACA is often referred to as payment reform instead of health care reform. Much of the legislative change required to fund universal access to care is predicated on changes in the health care payment system. Therefore, for PPACA to succeed, these organizations must adapt to the legislative requirements.

### **Research Purpose**

The purpose of this study was to determine the current culture of this selected segment of health care payment organizations to assess for characteristics of learning organizations that are considered best for adapting to revolutionary change. Through a better understanding of their current cultural landscape, this research provided these organizations with additional insight for enabling effective change practices. It is believed that a learning organization is better positioned to embrace the needed organizational changes prompted by the current revolutionary changes to this nation's health care system. One segment of the industry, the organizations involved in the administration of the payment reimbursement practices, was targeted for this study. By exploring their culture and readiness and/or abilities to function as learning organizations, their leaders and managers can be better prepared to embrace these revolutionary changes and figure out how best to integrate changes in their practices so that the ultimate goal of providing a cost efficient, equitable standard of care for all Americans can be achieved. In addition to the insight this study offered within the context of the PPACA changes, it also provided organizations in this segment an understanding of their culture and ability to adapt to other major changes they may face.

## **Research Questions**

1. What are the perceptions of experienced individuals within the medical reimbursement segment of the industry regarding their current organizational culture as measured by the organization's dominant characteristics, organizational leadership, management of employees, organization glue, strategic emphases, and criteria of success captured in the Organizational Culture Assessment Instrument (OCAI)?
2. How aligned are these health care payment organizations with characteristics of learning organizations?

## **Significance of the Study**

Both the Kaiser Family Foundation and America's Health Insurance Plans report that in 2008, the most recent time period for which information is available, health care expenditure in the United States surpassed \$2.3 trillion, accounting for slightly more than 16% of the nation's Gross Domestic Product, one of the highest of all industrialized countries (America's Health Insurance Plans, 2010; Kaiser Family Foundation, 2010). In a letter to the U.S. House of Representatives, dated December 15, 2009, Karen Ignagni, President and CEO of America's Health Insurance Plans expressed the insurance industry's concern with the continuing increase in costs and resulting escalation in insurance premiums. She indicated, "Efforts to make our health care system more affordable for the long run will succeed only if the nation as a whole makes a strong commitment to accountable mechanisms that will slow the future growth of health care costs" (as cited in America's Health Insurance Plans, 2009, p. 6). She goes on to inform the members of the House that the industry is "committed to working with you to develop

a plan to bring underlying medical costs under control and provide financially sustainable and affordable coverage” (p. 6).

Health care reform sweeps the country with the promise of universal health care coverage and, simultaneously, the cost of health care continues to escalate. Organizations in the health care industry must alter business practices to create a sustainable health care delivery system that can cover an incremental 40 million members without collapsing under the financial burden of meeting its promise. To fulfill this daunting task, organizations in the health care industry will need to find creative solutions for how they deliver services. Failure on the part of these organizations to adapt will have dire consequences, including:

1. The inability to provide universal coverage, which will result in an ongoing problem of how to care for a large population of uninsured and underinsured.
2. A collapse of the private funding system for insurance coverage whereby the increase in premiums resulting from legislated increases in benefit coverage renders private insurance unaffordable. As a result, individuals would opt out of private insurance into more affordable health cooperatives. A massive shift of this nature would create a de facto nationalized health care system.
3. Deterioration in the quality of care demonstrated by long delays in obtaining services as medical providers exit the market and funding is no longer available for necessary pharmaceuticals, diagnostic care, and overall health care.

To meet the yet ill-defined requirements of health care reform while creating a sustainable system will require health care payment organizations that adapt quickly to



these revolutionary changes. If culture is a critical component for driving change within organizations, then this study is critical to helping health care payment organizations understand whether their culture will support a learning environment that will adapt to change.

Additionally, while there are at least 18 studies that assess corporate culture (Ashkanasy, Broadfoot & Falkus, 2000), these have typically been used to determine how culture affects organizations' economic performance. There is a void in studies that consider how culture affects an organization's ability to adapt to significant changes in its environment. McLagan (2003), in an article reviewing why change efforts frequently fail, advises, "Creating a change-friendly organization is a new and still emerging pursuit. There are many experiments and some promising results, but there are as yet no robust models" (p. 52). This study provides an opportunity to use what is known about learning organizations and their ability to adapt to determine whether health care payment organizations demonstrate a culture that is consistent with these behaviors and position them to succeed in their fast-changing environment.

### **Delimitations and Assumptions**

The segment of the health care industry targeted for this study consisted of organizations focused on the administration of health care payment and reimbursement system. These include commercial insurance companies, third-party administrators, self-insured employers, health care consultants, health care cost management vendors, and technology firms that support these organizations. While these organizations have individual cultures as well as unique cultures within their market segments, to obtain an overall culture profile of the industry, it was important to include a wide spectrum of

organizations in this study. Individuals in middle or upper management and key staff positions with at least 5 years of tenure in the industry are assumed to have the knowledge and skills necessary to provide an accurate assessment of their organizations' cultures.

It was further assumed that regardless of what changes are made to the PPACA, its current provisions will continue to represent revolutionary change. Therefore, even if the legislation is significantly altered or repelled, this study still provides value to this segment in understanding its readiness to adapt to revolutionary change, regardless of its nature.

### **Conceptual Foundation**

The underlying issue for this study is revolutionary change within the context of health care reform. While numerous studies could be designed to help health care payment organizations adapt to a significantly changed system, this study focuses on organizational culture and specifically what characteristics within that culture can support organizations through revolutionary change. One perspective is that learning organizations are best equipped to adapt to change. Building on this perspective, this study explored whether health care payment organizations currently demonstrate the characteristics of learning organizations. Key areas of the literature used to develop and support this research included organizational change and how the PPACA constitutes revolutionary change for the health care industry, organizational culture, and characteristics of cultures considered to be learning organizations that are more adaptable to change.

## Definition of Terms

For this study of organizational culture and how it impacts the ability of health care payment organizations to adapt to the new external environment created by health care reform, definitions are provided in three categories: (a) health care commercial payment system, organizations, and reform; (b) organizational culture and learning organizations; and (c) change and adaptation to change. The definitions provided below include both theoretical and operational definitions.

**Health care commercial payment system, organizations, and reform.** The first category covers organizations in the health care payment system and health care reform. Definition of terms in this area are:

- Health care organizations supporting the payment system: This study targeted health care payment organizations that support the commercial health care payment system within the United States. These organizations include insurance companies that assume the risk for medical claims and pay for medical services on behalf of their covered patients; third-party administrators who provide the administrative services required to pay medical claims for employees of the companies that bear the risk and retain them to perform administrative services; cost-containment organizations that work with entities that bear the risk for medical expenses (such as insurance companies and employers) to negotiate reduced reimbursement for medical services with providers; health care benefit consultants who advise employers and administrators on all aspects of health benefit plan design, costs, and administration; and technology firms that support these organizations.

Individuals working within these organizations anticipated to have the knowledge and awareness of the organizational culture are those in middle and top management or key staff positions with at least 5 years of tenure in the industry.

- Health care reform: Refers to the PPACA signed into law on March 23, 2010, and frequently referred to as Obama Care. The purpose of this legislation is to eliminate the uninsured problem by increasing access to quality care while containing health care expenditures and mandating coverage for most Americans. Some of the major provisions of this legislation are to: (a) eliminate restrictions on coverage, (b) assure that a significant portion of medical premiums are spent on medical expenses as opposed to administrative expenses, (c) establish health care cooperatives that offer basic medical benefits at affordable rates, (d) create accountable health plans that base reimbursement to medical providers on quality standards instead of intensity of services as means to control medical costs, (e) establish penalties for failure to comply the requirements, (f) identify and prevent payment for fraudulent medical charges, (g) provide coverage for most Americans, and (h) reduce increases in payments to medical providers for Medicare services. See Appendix A for a more comprehensive summary of the legislative provisions and timelines.

**Organizational culture, climate, and learning organizations.** The second category defines culture and climate as well as learning organizations. Organizational climate is distinctly different from organizational culture. Culture is the result of the

deeply ingrained values, norms, and beliefs developed over time. Schein (2000) states climate is “embedded in the physical look of the place, the emotionality exhibited by employees upon entry, and myriad other artifacts that are seen, heard, and felt” (p. xxiv). Essentially, climate is how the organization’s culture makes the organization feel. For the climate to change, the culture needs to change first. Definitions in this area are:

- Organizational culture: An organization is a group of individuals. Schein (2004), in his classic book explaining how culture impacts the dynamics of organizations, defines the culture of a group:

As a pattern of shared basic assumptions that was learned by a group as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relations to those problems. (p. 17)

Harrison and Stokes (1992), in their introduction to their tool built to diagnose organizational culture, reinforce Schein’s definition of culture while also explaining how it impacts the organization when they state:

Organizational culture is the patterns of beliefs, values, rituals, myths, and sentiments shared by the members of an organization. It influences the behavior of all individuals and groups within the organization. Culture impacts most aspects of organizational life, such as how decisions are made, who makes them, how rewards are distributed, who is promoted, how people are treated, how the organization responds to its environment, and so on. (p. 1)

Cameron and Quinn (2006), the authors of the survey used in this study, define organizational culture as an “enduring, slow-changing core attribute of organizations [which is] implicit, often indiscernible [and] includes core values and consensual interpretations about how things are” (p. 147). The essence of organizational culture is captured in these definitions and supported widely in the literature (Beckhard & Pritchard, 1992; Burke, 2008; Sorensen, 2002). For purposes of this study, organizational culture was grounded in these definitions.

- Learning organization: Is an organization that learns from its experiences and applies these lessons to enhance continually its performance. Learning organizations traditionally demonstrate five characteristics. The first is a structure that promotes teamwork, information sharing, system thinking, and favors a flatter more flexible organizational structure over a hierarchical structure. The second characteristic is strong information system capabilities that provide for organized storing of information and ease of access to information that can provide value to others with the organization and its business partners. The third concerns human resource practices that encourage individual learning and performance through appraisal and reward systems that recognize this behavior. The fourth characteristic supports an organizational culture that stimulates creativity, information sharing, and experimentation. In this environment, individuals are encouraged to try new approaches and mistakes are recognized as one of the potential risks of creative thinking and innovation. The last characteristic of learning

organizations is leadership that provides a strong vision and models desired behaviors such as risk taking and the ability to reflect on past experiences to improve on future outcomes (Cummings & Worley, 2001; Marquardt, 2002; Senge, 2006).

**Change and adaptation to change.** The third category covers adaptation to change, organizational change, and revolutionary change. Definitions of terms for this area are:

- Adaptation to change: Senge (2006), in his book on learning organizations, quotes Ford's one-time Chief Information Officer, Marv Adams, who offers that in today's business environment, there is a high level of connectivity between organizations and that the environment is highly volatile. In this situation, he suggests that organizations that are able to build a capacity to deal with ongoing change are "adaptive organizations" (p. 275). In this study's context, adaptation to change means the ability to meet external environmental requirements while continuing to maintain or improve business results such as membership retention, market share, revenue, and profitability.
- Organizational change: Kanter, Stein, and Jick (1992) provide an overview of several well-recognized organizational change models offered by noted researchers such as Lewin, Tichy and Devanna, Nadler and Tushman, and Beckhard and Harris. These authors note that these models are generally based on a three-part process that takes the organization in its existing flawed state, moves it through a transition phase, and concludes with a revised state reflecting the changes from its initial state. Using the approach offered by

these models, organizational change can be summarized as the process that allows an organization to move from a current state of operations to a new desired state of operations.

- Revolutionary change: This type of change is also referred to as transformational change. Burke (2008), in his book on effective organization change, indicates this type of change “can be seen as a jolt (perturbation to the system). As a result nothing will ever be the same again” (p. 68). He emphasizes that in these circumstances, “survival depends on an entirely new *raison d’être* with completely different products or services or both” (p. 69). Golembiewski, Billingsley, and Yeager (1976) define this level of change as gamma change that creates change to a whole new state instead of a degree of change within an existing state. Gerseck (1991) likens this level of change as removing the hoops from the game of basketball, thus totally redefining the playing field.

## **Summary**

This study of how well the culture of health care payment organizations as learning organizations that adapt best to revolutionary change adds to the body of knowledge by: (a) defining the current culture that prevails in health care payment organizations within the segment that supports the payment administration and reimbursement system, (b) providing an initial understanding of how health care payment organizations need to adjust their cultures to adapt to the new environment created by this sweeping legislation or any other major environmental change, (c) expanding on what is known about the types of culture that best adapt to revolutionary changes by using culture



to determine the organization's status as a learning organization, and (d) offering empirical evidence that health care payment organizations can consider in identifying cultural changes they may need to make within their own organizations to adjust to revolutionary change. While the content of this study focused on a single segment of health care organizations within the context of health care reform, its findings establish a building block for future studies in other industries or pertaining to other significant external environmental changes health care payment organizations may face, especially those that are considered revolutionary or emerging.

Donald Berwick (as cited in Atlantic Information Services, 2010) in his first public speech since becoming the Centers for Medicare and Medicaid Services administrator in July 2010, advised:

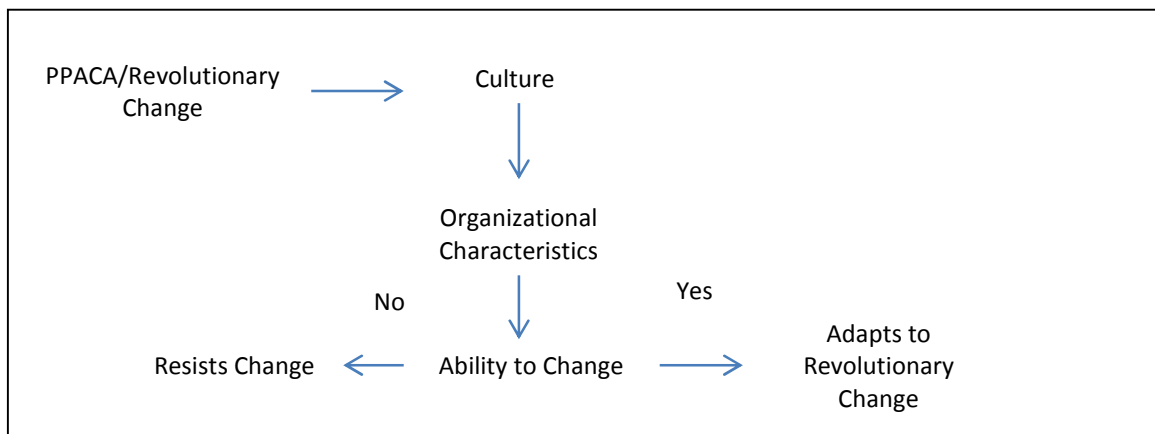
The care we want is not at all out of reach. We can have better care and less costly care at the same time. But to attain that goal, we will have to change. You don't get to the level of improvement that we need simply by trying harder. Those who wish to preserve the status quo are not going to be constructive contributors to our nation's future. They can't be effective partners because we need so much change.

(p. 2)

This study provides an understanding of the current culture of health care payment organizations. This data can assist health care payment organizations in identifying cultural changes they may need to make to adapt and become the constructive contributors and effective partners Berwick indicates are needed to meet the requirements of health care reform and the future health care needs of this country.

## Chapter 2: Literature Review

This chapter provides the theoretical foundation for this research and a review of related studies. The following areas are addressed: Organizational change and why the PPACA is considered revolutionary change, organizational culture, and learning organizations. To succeed in the new environment created by the PPACA, health care payment organizations need a culture that closely aligns with the characteristics of learning organizations, as these organizations are most able to adapt easily to change. Culture enables the behaviors that characterize the organization and, hence, is pivotal in whether the organization is already or can become a learning organization. Therefore, the culture of health care payment organizations is the determining factor regarding their ability to adapt to their new environment. Figure 1, Health care payment organization change model, illustrates the dynamics at play in the system within the constructs of this research.



*Figure 1.* Health care payment organization change model depicting the system dynamics pertaining to revolutionary change.

### Organizational Change

Experts agree that the external environment is changing at an increasing rate. They also concur that the environment is increasingly complex and interrelated (Burke,

2008; Kegan & Lahey, 2009; Kotter, 1996). This dynamic situation requires that organizations constantly adapt to the fluid environment to remain viable. Organizations that support the American health care payment system are faced with an unprecedented level of change within the industry to meet a complex and ill-defined new world created by the PPACA legislation. The need for change is not new. Organizations have historically explored how to enhance what they do to achieve better results or to accommodate new market or legislative demands. Some of the required changes were minor while others were substantial. Overall, the literature suggests change is difficult and often fails or falls short of the originally set goals (Beckhard & Pritchard, 1992; Beer & Nohria, 2000; McLagan, 2003). In this section, key constructs associated with organizational change and how the PPACA mandate constitutes revolutionary change for health care payment organizations is reviewed.

**Theoretical background.** Organizational change is the process of moving an organization or subunits of the organization from a current state to a new desired state. This definition is based largely on the work of Lewin (1997). Lewin warns that the focus should be on the change that needs to occur to achieve the goal. His theory is based on changing the equilibrium of what he calls the force fields competing for the status quo versus the desired state of affairs. Based on this premise, Lewin's model consists of three steps: Unfreezing, moving, and refreezing. The first step is aimed at reducing the forces that maintain the status quo, and the second step consists of developing new modes of operation to get the system to the desired stated. The final step is achieved when the organization reaches the desired new state of equilibrium and this new state becomes the status quo (Cummings & Worley, 2001). Gerseck (1991), in a review of theories on how

change occurs, explains that the common premise is that there are “long periods of stability (equilibrium), punctuated by compact periods of qualitative, metamorphic change (revolution)” (p. 12). She further states that systems have enduring deep structures that limit change until the pressure for change ultimately pushes the system to transform itself. Gerseck’s research on change demonstrates the same pattern presented by Lewin. Nonetheless, the Lewin change model has been criticized as simplistic based on the premise that organizations are dynamic and not frozen at any time. Another critique of this model is that change is not linear, it is evolutionary and messy (Burke, 2008; Kanter et al., 1992). Despite its shortcomings, experts on organization change have created change models that offer variations on Lewin’s work and validate the definition of change as moving the organization to a new state (Beckhard & Harris, 1977; Beer, 1980; Kotter, 1996; Nadler & Tushman, 1989).

A review of the literature suggests that there are different levels of change that vary depending on how broadly and deeply the changes impact the organization as well as the length of time within which the changes are implemented. The exact terms used to describe these levels vary. However, two patterns emerge within the literature. The first reflects changes that are controlled and represents incremental change that is typically internally driven in an attempt to improve performance within the existing strategy. This pattern is referred to as incremental, evolutionary, transactional, and coordination change. Golembiewski et al. (1976) suggest there are three types of change—alpha, beta, gamma. The first two occur within a well-defined frame of reference, with beta change being the result of changing perceptions. However, gamma change “refers to change from one state to another, as contrasted with a change of degree or condition within a given state” (p.

138). The authors indicate that this type of change is a “big bang” (p. 138). Bartunek and Moch (1994) offer a similar three-level change model in which first-order change represents incremental changes without disruption to core beliefs, second-order change explores the assumptions that drive the organization, and third-order change results in an understanding of and hence potential revision in mental models. Gamma change and third-order change reflect the second pattern of change, which is driven by the environment and is outside of the organization’s control. This change requires a redefinition of the core business and how it operates at all levels in order to survive. This level of change is revolutionary (Beckhard & Pritchard, 1992; Burke, 2008; Cummings & Worley, 2001; Gerseck, 1991; Kanter et al., 1992; Nadler & Tushman, 1989). In addition to the various scopes of change, Burke (2008) explains there are three levels of organization change—individual, group, and larger system. Individual change is isolated to the individual. Group change consists of individuals and is often the work team. The larger system change is the conglomeration of work groups to include several parts or all of the organization. He further indicates change efforts usually do not start all at once. They involve individuals, then groups, and ultimately some or all of the larger system.

Within the literature on organizational change there is consensus that to deal effectively with change, organizations must recognize they are open systems, continually interacting with their environments (Beckhard & Pritchard, 1992; Burke, 2008; Capra, 1996; Morgan, 2006; Nadler & Tushman, 1989). Not only does looking at organizations as open systems help with the understanding of what initiates change, it also emphasizes the need for organizations to recognize that they do not operate in isolation. Explaining what makes organizations more adaptable to their rapidly changing environments,

McLagan ( 2003) indicates, “that principles from life sciences are a better framework for thinking about organizations” (p. 58). Senge et al. (1999) as well, in his guide to organizational change, indicates that to “understand why change is often not sustainable we should look at organizations from a biologist’s perspective” (p. 6). Clearly, there is agreement that organizations are part of a greater system, which is their environment. The system impacts them and they impact the system. To be sustainable, these organizations must interact effectively with their environment.

**The PPACA.** The PPACA changes the environment within which health care organizations operate. These changes are currently outside the control of the organizations and require adhering to a whole new set of often poorly defined rules. Health care reform is a larger system change, as it impacts the overall strategy of health care organizations. The new environment requires that health care organizations rethink their business models, strategies, and operations and ensure their culture allows them to adapt to the required shifts. The changes are deep and immediate and fall within the second pattern of changes, which can be summarized as revolutionary.

PPACA has nine components (“Responsible Reform,” 2010). Some of these components impact health care payment organizations directly by mandating operational guidelines and reporting requirements; others have no direct impact but will impact the environment in which these organizations operate with a need to monitor closely potential cost shifting practices by medical providers; and some should have no impact on these organizations. The key driver of change for health care payment organizations is the component of the legislation that mandates quality, affordable health care for all Americans. This provision expands benefit coverage by eliminating preexisting

provisions and out-of-pocket limitations, mandating certain preventative care benefits, simplifying benefit coverage information, mandating ratios on expenditure of medical versus administrative expenses, and creating health exchanges to provide affordable coverage to individuals and small employers. In the past, insurance companies and self-insured employers could design plans according to their business needs and pricing considerations. Now, the government is telling them what they will cover and also requiring administrative efficiency by mandating that 80%–85% of medical premiums be allocated to pay for medical and quality initiatives. Simultaneously, the government is increasing competition by creating health exchanges to allow individuals to shop for lower-cost plans and, under the legislative component that mandates “improving the quality and efficiency of health care” (p. 4), establishing accountable health plans with which reimbursement to providers is tied to quality instead of intensity of service. Additionally, the legislation’s revenue provision has a stipulation that could result in a tax on the sponsors of high-cost plans, also known as Cadillac plans. Finally, the universal coverage provision that mandates coverage for most Americans increases the number of covered lives that medical insurers will need to cover while also increasing the patient load for medical providers.

While these four provisions have the most direct impact on health care payment organizations, it is important to note that the other provisions of the legislation will change the overall dynamics of the health care payment system primarily by potentially reducing provider reimbursement for government-sponsored plans and mandating greater transparency. These changes are likely to put yet more pressure on health care payment organizations as medical providers shift costs to the private sector to compensate for cuts

in payments from publicly funded plans. The PPACA requires that health care payment organizations change their product design, their administrative practices, and their underwriting policies while absorbing added volumes of insured lives within a system in which increased competition will exist and medical providers will try to shift costs to these entities. Health care payment organizations will need to determine quickly how to deal with these new dynamics without increasing premiums to a level that will drive existing and potential new customers into the lower-cost government-sponsored alternatives. Simultaneously, they will need to determine how to capitalize on the new number of insured lives entering the market. To maintain their market position, these organizations need to revisit how they have traditionally done business and find ways to adapt to their new environment. This scope of change is no less than revolutionary.

**Studies on change.** A review of studies on organizational change indicates a focus on what drives organizations to change and what components lead to successful change. A McGreevy (2009) study specifically identifies newly enacted legislation as one of the drivers for complex adaptive change in 49 organizations within diverse industries in the United Kingdom. His findings indicate that in most instances, the changes required by the legislation are met. Likewise, He and Baruch (2010), in a study of two British construction companies' ability to handle change, attribute legislative changes as one of the triggers requiring these organizations to adapt. Several other studies speak to a change in the environment as creating the trigger for the change. A case study of the changing environment Xerox and Motorola encountered as a result of new entrants into the market makes a case for scenario planning to breakdown mental models and prepare for shifts in the environment (Wright, van der Heijden, Bradfield, Burt, & Cairns, 2004). In a study of



strategic change in nine organizations, Flamholtz and Randle (2008) indicate that environmental changes were a factor in the need to adapt in eight of the nine cases. These studies indicate that changing environments including legislative changes are often what elicits organizational change. The PPACA presents a current example of such a trigger for health care payment organizations.

***The role of organizational culture in change.*** A common thread within the studies was the role of organizational culture in either facilitating or obstructing change within organizations. In a case study of two family owned oilseed exporters in Argentina, Hatum, Pettigrew, and Michelini (2010) found that organizational culture was a key factor in allowing one organization to adapt while holding the other back. Smollan and Sayers (2009), in a study of the relationships among culture, emotions, and change, report, “organizational culture...as a potentially relevant factor in the ways in which people respond to change” (p. 451). They conclude, “Organizational change has the capacity to alter culture...conversely, the culture affects the way in which staff respond to the change on an emotional level” (p. 452). In a case study of a health care delivery system in Missouri trying to change the quality standards within the organization, Brinkman and O’Brien (2010) recognize the importance of culture in change initiatives when they indicate that their focus was on changing the culture of the organization to achieve the desired goals. Speaking specifically to revolutionary change in their study of nine organizations undergoing strategic change, Flamholtz and Randle (2008) found, “management systems and corporate culture are key levers in the change process” (p. 243). Across the various studies, culture is recognized as a key component to enabling or acting as a barrier to change.

***The influence of having a culture for learning.*** Another contributing factor to successful change that emerges in these studies is that organizations that experience successful change have many of the characteristics of learning organizations. In a study of 90 public and private entities in Norway to identify what constitutes healthy change and develop guidelines for change, the authors found the following factors were important: Awareness of norms, diversity, early role clarification, manager availability, and constructive conflict (Saksvik et al., 2007). In their study on Xerox and Motorola's inability to adapt to environmental change, Wright et al. (2004) blame lack of awareness of mental models and lack of honest communication for the inability to adapt to the changing environment. Chrusciel and Field (2006), in a study of factors that need to be present to optimize change transformation, identify the following: A clear understanding of why the change is needed, appropriate planning, staff participation in the transformation process, and active feedback throughout the process. In his study to determine why change initiatives are frequently unsuccessful, McGreevy (2009) found that the organizations he surveyed, when reflecting what they would do differently, often cited behaviors consistent with those of learning organizations. These studies suggest successful change requires the organization demonstrate the characteristics of learning organizations.

***The impact of the environment for change.*** A number of studies focused on change recognized the role the changing environment has in triggering change, the importance of culture in enabling change, and that learning organizations' characteristics frequently contribute to successful change. All of these elements reinforce the components of this research. However, only a single recent study was found pertaining to

the targeted business segment of the health care industry focused on in this research.

Daniels (2007) reported on the implementation of Six Sigma by Cigna, one of the largest health insurance companies in the nation. Even prior to the inception of the PPACA, then CEO Edward Hanway recognized “dramatic changes were moving on the horizon” (as cited in Daniels, 2007, p. 43). Many of the changes he foresaw, such as a shift away from cost-based models toward quality-based models, demographic changes requiring additional access to care, and a focus on quality and transparency, have been exacerbated by the PPACA. Cigna’s solution to these market dynamics was to implement Six Sigma, which required adopting many of the behaviors found in learning organizations, including a clear vision and ongoing assessment of projects.

**PPACA as revolutionary change.** PPACA represents revolutionary change for health care payment organizations. A review of recent publications on the subject confirms this legislation “will change the nature of the insurance business” (Brennan & Studdert, 2010, p. 1147). Watts and Cuthberg (2011) remind us the legislation is 2,400 pages and advise that it will impact the majority of employers and their employees. They suggest immediate action and intense communication are required to deal with this massive legislation. Both Cigna (2011) and Aetna (2011), major health insurers, make mention of the PPACA in their 2010 annual reports. In his letter to the shareholders, Cigna’s CEO, David Cordani, advises, “This is a time of extraordinary change and extraordinary opportunity” (as cited in Cigna, 2011, p. 7). Ronald Williams, Aetna’s Chairman, states, “The next 10 years will be a critical time for health care. America will continue to work toward building a better health care system” (as cited in Aetna, 2011, p. 2). He goes on to say, Aetna “will capitalize on opportunities that come from reform and

the entry of millions of new customers into the marketplace” (p. 2). In a review of what we can learn from the health care reform enacted previously in Massachusetts, Jonathan Gruber commenting on the PPACA warns that it will “transform the operations of health insurance markets in the U.S.” (as cited in Couch, 2011, p. 184). He goes on to state:

[This is] one of the most transformative pieces of social policy legislation ever passed into law in the U.S. As a result, it is incredibly difficult to make strong predictions about the impact it will have on health insurance markets and health care. (p. 191)

In reviewing the potential impacts of the legislation on large employers, Darling (2010) tells us these organizations will reassess their health care strategies and may find that their best approach is to change what they have traditionally done with providing employee benefits. In an article highlighting the areas of the legislation that remain ill-defined, Wilenski (2011) advocates that in this uncertain environment one thing is clear, “providers and insurance companies can expect significant changes in the future” (p. 36). He further indicates that until all is defined, “providers and insurance companies will need to learn to live with uncertainty as a way of life—at least for the next several years” (p. 36). Overall, there is consensus that the PPACA has created a revolutionary change in the way health care payment organizations operate.

A review of the literature also reveals that many of the requirements of the PPACA remain unclear. In an article dealing with employee communication on health care reform, Watts and Cuthbert (2011) advise the legislation “raises more questions than can possibly be answered in the short term” (p. 2). Commenting on whether two of the major funding mechanisms for the reform will ever be enacted, Douglas Holtz-Eakin

suggests that political pressure will kill the Medicare payment reductions to providers. He further indicates that the tax on high-cost plans has already been deferred to 2018 because of pressure from the unions and is unlikely to ever come to fruition (as cited in Couch, 2011). Miller (2010), in an article on the politics of health care reform, suggests the current legislation represents only a cease-fire in a long political battle, as those who favor the legislation and those who argue against it continue to fight over the final letter of the law. In an article reviewing the impact of the legislation on large employers, Darling (2010) recognizes the many unknowns regarding implementation and impact. Likewise, Wilenski (2011), in an article exploring the continuing uncertainty surrounding the PPACA, suggests unanswered questions have been compounded by legal challenges, the current financial crisis in many states, and how much flexibility the current administration will allow in the interpretation and implementation of the legislation. Because of the complexity and scope of the PPACA and the politically charged environment surrounding its passage, experts in the industry agree that many aspects of the legislation are still ill defined and subject to negotiation. Therefore, not only do health care payment organizations need to adapt to the current provisions, but they also need to be able to change course quickly as further definition and developments evolve. The scope of mandated requirements reaches every aspect of the health care system. At this stage, some of the provisions have already been implemented while others are still being defined. These changes provide a good example of the need to encompass systems thinking into the culture of health care payment organizations. As the individual mandates are implemented, they not only have a direct impact on the entities they are directed toward, but also a likely potential impact on other parts of the system. This

secondary impact will require that health care payment organizations anticipate the potential repercussions and revisit their mental models to find creative ways to address them. They will need to define how their vision applies to these new conditions and act rapidly to maintain their competitive edge. To keep pace with these changes they will also need to engage effectively and empower all their resources to address their new environment. Essentially, health care payment organizations will need to demonstrate the characteristics of learning organizations. If they have an adaptive culture, they will be better positioned to meet the challenges this sweeping legislation presents.

In dealing with the revolutionary changes brought forth by the PPACA and the uncertainty created by the legislation, authors on the subject suggest health care payment organizations will need to be adaptable to this new and evolving environment. In his letter to the stockholders, Ronald Williams, Aetna's Chairman, indicates, "We are confident in our ability to adapt to a new health care landscape and help our customers do the same" (Aetna, 2011, p. 2). David Cordani, the CEO for Cigna, notes in his letter to stockholders that the organization has shown the ability to adapt to changing markets (Cigna, 2011). Both executives recognize the need for adaptability in this fast-changing environment. In a review of how health insurers are expected to respond to the new rule of the PPACA, Brennan and Studdert (2010) suggest the legislation creates significant obstacles and opportunities for insurers and that those that adjust rapidly will acquire a competitive edge. He goes on to predict this will be a different world for insurers and that the organizations that are best prepared will also be the ones that succeed in this new environment.

## **Organizational Culture**

This section reviews what has been written about organizational culture. It provides the theoretical background on what culture is, explains how culture impacts organizational change, and presents the characteristics of adaptable cultures. It also reviews current studies regarding organizational culture and then elaborates on what is known about learning organizations from a theoretical perspective as well as from recent empirical studies.

**Theoretical foundation on organizational culture.** Schein (2004), in his book on organizational culture and leadership, defines the culture of a group as:

A pattern of shared basic assumptions that was learned by a group as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems. (p. 17)

He advises that critical aspects of culture are the norms and rules that guide the group (Schein, 1999). Schein explains that there are several levels of culture. The deepest level is based on the underlying assumptions that are unconscious and lead to the actions of the individuals within the organization. This last level is the foundation of the organizational culture, which ultimately directs its actions. Noted authors on the subject of organizational culture agree that culture is based on norms developed over time from actions and behaviors that have served the group well. As the culture becomes established, it reflects the group values and the norms are implicit and often not easy to identify. These norms are passed on to new group members and applied to new situations (Beckhard & Pritchard, 1992; Cameron & Quinn, 2006; Schein, 1999; Schein, 2004).

While organizational culture is typically thought to be based on the deeply held assumptions of organizational members, Schein (1996), in an article on organizational learning, warns that the culture of the organization is also impacted by outside professional communities. He advises that when organizations attempt to reinvent themselves because of new environmental conditions, they may find conflicts between these professional communities and other internal factions. Schein uses this situation to remind the reader that to avoid failure of change efforts, we need to take culture seriously. This concept offers an interesting perspective when considering the changes health care payment organizations must make to adapt to health care reform. Since this change impacts the industry as a whole, it is likely that the executives and the technical experts will actively consult with their respective peers in other organizations regarding implementation of the legislation and lobbying efforts to change or repeal the law. This collaboration is likely to reinforce current industry practices that could potentially further complicate internal implementation of needed changes within the organizations.

Schein (2004), in his book on organizational culture and leadership, advises that culture provides stability in how the organization acts. He also says that because culture brings stability through consistent and expected behaviors and because people value stability, culture is difficult to change. Harrison and Stokes (1992) expand on Schein's insight regarding the wide-reaching aspects of culture when they indicate it governs how organizations operate internally such as how decisions are made; how people are treated, promoted, and compensated; and externally in how organizations interact with their environment. These authors indicate culture, while difficult to pin down, has a significant impact on how organizations behave. The stability provided by a strong culture is



beneficial when the environment is stable and when competition is minimal. However, in a turbulent and rapidly changing environment, a strong culture can anchor the organization into adhering to a set of norms that is no longer appropriate for the evolving conditions (Cameron & Quinn, 2006; Kotter & Heskett, 1992; Schein, 2004). In a study that measures the correlation between the strength of culture and performance, Sorensen (2002) concludes, “Firms with strong cultures incur a tradeoff with respect to their adaptive ability in the face of environmental change” (p. 98). The literature suggests that it is important for organizations to have an adaptable culture that, even if deeply ingrained, will allow organizations to respond effectively to revolutionary change such as health care reform.

***Environmental changes prompting shifts in culture.*** The need to change culture within organizations occurs when its environment shifts, causing the organization’s performance to decrease and putting its survival at risk. Under these conditions, the old norms that evolved as a result of their past successes may no longer be effective (Cameron & Quinn, 2006). In responding to environmental changes, organizations reevaluate their strategies and while these may be sound, if they do not correspond with the deep underlying norms that govern the organization, they will fail (Cameron & Quinn, 2006; Kotter, 1996; Kotter & Heskett, 1992; Schein, 2000; Schein 2004; Sorensen, 2002). Cummings and Worley (2001) support the importance of considering culture when implementing strategy in their book on organizational change when they advise that in today’s dynamic environment, assuring that there is a close link between the culture and the business strategy can make the difference between success and failure. Kotter and Heskett (1992) explain why a lack of alignment between culture and strategy

occur. They indicate that culture blinds, even highly capable people, when information doesn't match their assumptions. As a result, these individuals ignore critical information patterns that do not fit within their mental models. This gap between reality and perception leads to failure.

***Changing the organizational culture.*** Given the ingrained nature of culture, one wonders how it ever changes. Schein (2004) suggests that crises create new norms and reveal important underlying assumptions. He explains that crises create anxiety, which people do not like. In an effort to reduce the anxiety, individuals are more open to new ways of thinking. If these fresh perspectives result in positive outcomes, the organizational members will have learned new behaviors, which will lead to revised basic assumptions. While not necessarily advocating the need for a crisis to change culture, Schein tells us he is convinced that there must be "some sense of threat, crisis, or dissatisfaction...before enough motivation is present to start the process of unlearning and relearning" (p. 324). Health care reform presents a threat to the established ways of health care payment organizations. Therefore, this event will test the culture of health care payment organizations and potentially promote fresh thinking, making these organizations more adaptable.

While the literature indicates culture is an important factor in implementing change, it is not clear whether culture should drive or follow change. Schein (2000), in an article providing insight on culture, warns, "Management should seek not to change culture, but to change effectiveness. Only if it can be shown that the culture is actually a constraint should one launch a culture change program" (p. xxix). In his book on culture and leadership, he adds that leaders should not assume that organizational change

necessarily requires a culture change (Schein, 2004). Kotter (1996) is more forceful in his opinion that culture change should occur in the latter stages of change efforts, not lead them. He recommends letting the new behaviors produce benefits in performance first. However, he cautions that there still needs to be a high degree of awareness regarding the existing culture and the need to address specific mental models. While there is discussion as to when culture needs to be addressed and at what level it needs to be addressed when major change is indicated, culture is recognized as having an important role in how an organization behaves and transforms itself to meet new market conditions. In his study exploring how culture impacts performance, Sorensen (2002) summarizes the dynamics of culture in change when he warns environmental change can create internal issues, creating chaos in challenging the way things have always been done. Likewise, it can require a revision of how the organization needs to deal with its environment. The organization needs to learn how to function internally and externally to deal successfully with the new conditions. Culture may not always be the starting point for change. Nonetheless, it needs to be understood and factored into any change efforts to understand whether the culture will enable or hinder change efforts.

As is the case for health care payment organizations, where change is imminent, Pritchett (n.d.) reminds us, “Change has no conscience. Doesn’t play favorites. Takes no prisoners. And change ruthlessly destroys organizations with cultures that don’t adapt” (p. 2). Given this reality, it is important for organizations to understand the type of culture that allows them to adjust rapidly to their changing environment. Pritchett recommends the following behaviors to help organizations adapt effectively: Create a culture that is fast. He suggests building speed and responsiveness in everything the company does;

remain steady under pressure. Don't take a wait-and-see attitude, but show initiative and independence in dealing with new situations; create a culture of action not complacency where the organization is willing to do things differently. He says the secret is to simplify, look for new solutions, increase efficiency without sacrificing quality, and be willing to make radical changes.

Kotter and Heskett (1992), in their book on corporate culture and performance, suggest that cultures that are not adaptive are typically bureaucratic and focused on short-term results while those that adapt well to change were more entrepreneurial, and encouraged candid discussion, prudent risk taking, innovation, and flexibility. In his book on implementing change in organizations, Kotter (1996) states that an adaptive culture will be needed for organizations to survive. He indicates adaptive cultures value performing well for their constituencies (they realize they are part of a system), support competence, encourage teamwork and minimize bureaucracy and interdependence. Schein (1993), in an article on the importance of dialogue on culture and organizational learning, advises, "Because of the increasing rate of change in the environment, organizations face an increasing need for rapid learning" (p. 40). In his subsequent book on organizational culture and leadership, he states a learning culture is adaptive, learning oriented, and flexible. He indicates this culture is proactive in solving problems and anticipating environmental change; committed to learning, including ongoing feedback and reflection; empowers employees; is less hierarchical; attempts to achieve control over its environment; encourages inquiry; adopts a futuristic view that incorporates systems thinking; is committed to open communication; embraces diversity; and is devoted to understanding and improving culture (Schein, 2004).

The literature indicates that strong cultures may blind organizations to current conditions, making it difficult for them to adapt to new conditions. Schein (2004) suggests that an adaptable culture resolves this paradox because its foundation is built on learning and flexibility instead of stability. The characteristics of adaptable cultures include: Speed, creativity, willingness to take risk, open communication, systems thinking, revisiting mental models, and being flexible, not bureaucratic.

**Recent empirical studies on culture.** A review of current studies on organizational culture reveals some recurring themes. One theme is that culture is an important factor in enabling organizational change. The other speaks to the characteristics of organizations with adaptable cultures. The studies were conducted worldwide and often focused on manufacturing, engineering, and construction organizations. One case study highlighting a change effort at a hospital-based medical delivery systems organization was identified. This study was the closest to the health care payment organization segment being studied in this research. However, no studies were found that involved health care payment organizations (Gertner et al., 2010). Looking at how culture affects organizations' ability to change, Danisman (2010) explores the impact of societal culture on organizational change. The author's study of a Turkish organization finds that culture within an organization shapes resistance to change and that the societal culture influences this resistance. He concludes that when contemplating a meaningful change, organizations need to understand their culture and that of the society within which they operate. This insight provides an interesting perspective on why there may be so much resistance to the PPACA, especially within the conservative segments of the U.S. and how this societal resistance may impact the ability of the health care payment

organizations that need to adapt to the new legislation. In a study that reviews 70 instruments that measure organizational culture, Jung et al. (2009) acknowledge that one of the reasons these instruments are needed is that culture is recognized as “one of the most significant factors in bringing about organizational change” (p. 1087). They conclude that when selecting an instrument to measure organizational culture, it is important to determine first the purpose of the assessment and how the information will be used. The authors explain that this understanding will provide for the selection of the right instrument. In a study exploring the role of emotions and how they tie to organizational culture and change in a number of industries in New Zealand, Smollan and Sayers (2009) found, “It is important to acknowledge the role culture plays in facilitating or impeding organizational change” (p. 449). In a study of an athletic footwear organization and of a health care medical delivery system that changed their practices to adapt to new environmental conditions, the authors found that culture change can occur as a result of individuals within the organization making small changes in how things are done. Over time, if these new approaches are successful, they will be adopted on a broader basis within the organization and create change by changing the culture with elements of an organization’s existing culture. These findings challenge the traditional thinking that change evolves only from major jolts to the organization. However, the authors acknowledge once again the importance of culture in the change process. Howard-Grenville, Golden-Biddle, Irwin, and Mao (2011), in a study of how change can occur in the absence of major jolts, find that while this happens, it is important to have a corporate culture that is adaptable.

The studies that explore culture frequently identify characteristics that help or hinder the ability for organizations to change. In a study of how a Turkish organization adapts to change, Danisman (2010) describes the elements that arrest the change process as bureaucratic practices where all decisions are controlled by the CEO. He goes on to report that the employees had little autonomy or decision-making authority. Fang and Wang (2006) conducted a study of how manufacturing industries select their strategies based on their culture and organizational learning. They found that culture and organizational learning are significant factors in how manufacturing organizations select their strategies. The authors conclude that to remain competitive, “firms need to create an organizational climate with a strong corporate culture of continuous learning and innovation” (p. 511). In a study on how organizational culture shapes learning organizations in Iranian public organizations, Fard, Rostamy, and Taghiloo (2009) found that out of four types of cultures—bureaucratic, competitive, participative and learning—the learning culture demonstrated the most significant relationship in creating a learning organization, validating the importance of culture in shaping organizational behavior. In exploring how cultural change can emerge from gradual changes in behaviors instead of being triggered by major jolts, Howard-Grenville et al. (2011) indicate that a spirit of experimentation is prevalent. However, the authors also acknowledge once more the importance of culture in the change process. Gertner et al. (2010), in their case study of change to accommodate cultural factors within a Pennsylvania medical health care system, offer several examples of characteristics they found essential in implementing the changes. These include speaking honestly, shared vision driven by leadership, clear communication, challenging mental models and incorporating double-loop learning,

collaboration, and management commitment to resources. Interestingly, the environmental factors driving these changes have much in common with the conditions facing the health care payment organizations under study in this research.

**Summary of organizational culture review.** A review of the literature and of recent studies confirms that culture is a critical factor in driving organizational change. Additionally, the studies identify the characteristics that assisted organizations in adapting to change. Many of these characteristics are found in learning organizations. Organizational change, especially revolutionary change such as that triggered by the PPACA, is not easy. Getting from a current to a new state involves a transition phase, which involves a period of uncertainty. Culture has been shown to play a critical role in organizations' ability to change, and certain types of culture are more adaptable than others.

### **Learning Organizations**

Manville (2001), in an article on positioning organizations for turbulent times, advocates that organizational learning is critical for organizations to adapt and survive market shifts and intense competition. He says that learning "is the shock absorber for the speed bumps of change [and] the glue that aligns human capital across organizational boundaries" (p. 37). The literature indicates that the characteristics of adaptable organizations include committed leadership, strong communication, a well thought out process, a shared vision, proper resource allocation, and most important the ability to learn from the process (Beckhard & Pritchard, 1992; Beer, Eisenstat, & Spector, 1990; Beer & Nohria, 2000; Kanter et al., 1999; Kotter, 1996; Nadler & Tushman, 1989; Spector, 1989). Considering the steps required for moving from the present to the desired



state, the complexity presented by open systems, and the uncertainty that surrounds the transition phase, it is no surprise that the experts recognize the ability to learn as a key part of an effective change process. It is also interesting to note that the recurring themes identified as enabling change have much in common with the characteristics of learning organizations.

**Theoretical foundation on learning organizations.** Many authors suggest that given the fast pace of change and complexity of the current and emerging environment, organizations that will thrive will be those with a workforce that has developed the capacity to learn (Argyris, 1991; Beckhard & Pritchard, 1992; Marquardt, 2002; Senge, 2006; Thompson, 1995). Garratt (1987) first described learning organizations in his book, *The Learning Organization*, in which he suggests that to compete effectively, organizations must create feedback loops between units and management to learn from one another's experiences. However, Senge is widely recognized as the premier authority on learning organizations (Abu Khadra & Rawabdeh, 2006; De Villiers, 2008; Moilanen, 2005; Yang, Watkins, & Marsick, 2004). In his noted book on the subject, *The Fifth Discipline*, Senge (2006) defines learning organizations as, "Organizations where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning how to learn together" (p. 3). Learning organizations are places where the workforce achieves great things through a collective process of information sharing that moves them toward a common goal at a higher speed than experienced in nonlearning organizations.

***Senge's learning organization characteristics.*** According to Senge et al. (1999) there are five characteristics, which he calls disciplines, of learning organizations. The first characteristic is personal mastery, which involves exploring the gap between current reality and personal vision and increases the capacity to make choices leading to better results. Senge (2006) explains that unless individuals within organizations learn, the organizations cannot learn. He further advises that individuals with this discipline are continually validating what is important to them and delving into the current reality. They recognize that they are part of a system and can only reach their goal in conjunction with others. These individuals seek an organizational vision that supports their personal objective and, hence, find creative ways to bridge the gap between the current state and desired state. They look at shortfalls as an opportunity to learn. Therefore, they are creative and comfortable in taking risks. Leaders of learning organizations need to foster this skill by creating an environment in which individuals feel safe in challenging the status quo, seeking the truth, and pursuing their personal vision. Buono and Kerber (2010) concur with these characteristics and they advise that to create a culture of change, managers throughout the organization must embrace organization-wide learning by promoting inquiry and investigation, sharing of information, entertaining new viewpoints, and tolerating mistakes that result from experimentation.

The second characteristic involves exploring mental models by encouraging reflection into personal worldviews, which increases the capability to govern actions, interactions, and decisions (Senge et al., 1999). Senge (2006) explains that mental models hinder the consideration of new ideas. These models result in individuals interpreting information based on their long-held worldviews. Therefore, new ideas that conflict with

these mental models are discarded without being properly considered. Senge indicates that the discipline of managing mental models requires that individuals explore, surface, and test their worldviews. He believes this process of constant reflection and inquiry is critical in building learning organizations that will make better decisions. Likewise, Marquardt (2002) tells us mental models are based on deeply rooted assumptions that guide our actions and influence our interactions with others. Argyris (1977) offers yet another view of how mental models hinder learning. He refers to a study he and Donald Schon conducted in which they explain the difference between double-loop learning, where individual actions are predicated on obtaining valid information to solve issues, providing others with a choice in how to solve the problem, and learning through the implementation instead, and a single-loop approach that does not challenge mental models and fixes the problem without understanding the core issues. He suggests that double-loop learning is collaborative, promotes learning, and does not present the individual as defensive. He tells us that double-loop learning encourages creativity, truth seeking, and risk taking. Through this exploratory process, learning is enhanced and effectiveness is increased. Bartunek and Moch (1994) indicate that the ability to understand, challenge, and revise mental models is critical to effecting third-order (revolutionary) change by recognizing that accepted approaches may no longer provide solutions for the future.

The third characteristic of learning organizations is shared vision with which there is a mutual purpose that drives commitment to a shared future vision (Senge et al., 1999). Senge (2006) indicates that vision is “the future we seek to create” (p. 208). He tells us that a shared vision is common between individuals who are committed not only to the

vision but to each other in realizing this vision. He believes that shared vision is critical for learning organizations because it generates the energy and focus for learning. Marquardt (2002) suggests that this vision sets the direction for the future of the organization, which is enhanced by the learning of the individuals within the organizations in their pursuit of the vision. He also advises that this provides focus and energy, impels people toward action and encourages them to be more open in their thinking, encourages challenging the status quo that gets in the way of the vision, and helps determine what knowledge is important. Dilworth (1995), in an article about the DNA of learning organizations, highlights the importance of shared vision in creating a true learning organization. Nadler and Tushman (1989), in an article featuring a process for organizational change, indicate vision provides a picture of what the organization will look like following the change. Senge (2006) explains that once people make this vision a personal goal, it will promote creativity and risk taking as well as generate the energy necessary to move the organization toward its desired end state.

The fourth characteristic is team learning, which emphasizes purposeful group interaction through effective communication, resulting in higher overall results than individual contributions (Senge et al., 1999). Senge (2006) explains that team learning is the result of alignment whereby a team of people function as one unit. This condition results in harmonizing instead of wasted energy. The team members understand how to complement one another. Senge tells us there are three critical dimensions to team learning: The first is the ability to tap into each other to address complex issues more comprehensively; the second is the need for creativity in tapping into the team to complement each other to reach solutions or take action; and third, as team members

participate in other teams, they will bring the insight they gained from one team to another, which broadens the circle of learning. He advises, “The discipline of team learning involves mastering the practices of dialogue and discussion, the two distinct ways that teams converse” (p. 220). Senge indicates that when dialogue occurs, the team can address difficult issues and entertain the point of view of the multiple team members by being honest about their individual mental models and communicating their assumptions. He suggests this open communication is difficult in hierarchies whereby individuals may find it intimidating to open up with senior members of the organization. However, when dialogue is possible, the level of trust among the team members grows, which promotes creativity. Schein (1999) indicates, “Dialogue as a form of conversation starts with the assumptions that every person comes with different assumptions and that mutual understanding is in most cases an illusion” (p. 202). He explains that dialogue can create a climate that promotes learning and is the only way to resolve conflict rooted in different assumptions. He further indicates that dialogue allows the team to reach a higher level of creativity through shared meaning and common thinking . When a group is able to use dialogue, he indicates, “the whole group is the object of learning and the members share the potential excitement of discovering, collectively, ideas that individually none of them might ever have thought of” (p. 44). Team learning enables the organization to explore more honestly and effectively potential issues holding it back from higher performance.

The fifth characteristic of learning organizations, which Senge et al. (1999) also indicates is the most important, is systems thinking, which realizes a better understanding of interdependency and change. This characteristic focuses on how to deal more

effectively with the forces that result from our actions. It is based on feedback and complexity and ties together all the other disciplines. Senge (2006) indicates that the impetus for developing learning organization capabilities comes from trying to create adaptable organizations by developing human and social capital to improve financial results. Nowadays he believes there is awareness that organizations reside within other systems, which ultimately creates a universal bond and where learning organizations can create a better future for all. Marquardt (2002) indicates, “Systems thinking represents a conceptual framework with which to make full patterns clearer and determine how to change them effectively” (p. 26). Morgan (2006) advocates that to be successful, organizations must be alert to changes within their environment to assess future possibilities. These organizations realize that their environment affects them and that they in turn affect the environment by their actions. Cummings and Worley (2001) advise that systems thinking provides the tools to see structures and forces they otherwise would not detect and to assure their theories in practice effectively deal with this increased level of complexity. Individuals within learning organizations realize that the skills of personal mastery, mental models, shared vision, and team learning work together to create a more effective organizational system. This system, in turn, operates within an external environmental system. By using all the learning skills, the organization will create a system that optimizes learning and allows it to meet more effectively environmental demands.

***Other characteristics of learning organizations.*** Adding to Senge’s characteristics, other authors indicate that learning organizations are not bureaucratic. They are flexible and not hierarchical. They use their employees effectively and cross-

functionally in a manner that taps into the best qualified individuals to address the issue (Beckhard & Pritchard, 1992; Cummings and Worley, 2001; Kanter, 1995; Kotter, 1996; Marquardt, 2002; McLagan, 2003). Learning organizations are typically fast in implementing new strategies and products. They also actively promote ongoing improvements and changes and are fast at identifying and solving problems. These organizations demonstrate an ongoing sense of urgency (Kanter, 1995; Kotter, 1996; Marquardt, 2002; McLagan, 2003). Another commonly cited characteristic of learning organizations is that they encourage innovation and risk taking. They are open to new ideas and encourage creativity. They accept that failure is part of the learning process (Beckhard & Pritchard, 1992; Cummings & Worley, 2001; Kotter, 1996; Marquardt, 2002; McLagan, 2003). Learning organizations also share information effectively. They are good at identifying and disseminating needed knowledge. They build systems and adopt technology that assists them in communication. These organizations build effective communication systems geared to promote perpetual learning and to assist with training. They continually encourage acquisition of new knowledge and skills and sharing of this new information with coworkers (Beckhard & Pritchard, 1992; Cummings & Worley, 2001; Kotter, 1996; Marquardt, 2002; McLagan, 2003). The literature also indicates that learning organizations must have people who create and communicate the organization's vision and that the leaders of these organizations must model the skills required of learning organizations (Cummings & Worley, 2001; Kotter, 1996; Marquardt, 2002).

Learning organizations that demonstrate these characteristics have cultures that are externally oriented and empowering, have a sense of urgency, promote openness, are more risk tolerant and promote creativity, and adapt well to change (Cummings &

Worley, 2001; Kotter, 1996; Marquardt, 2002; McLagan, 2003; Senge et al., 1999).

Ford's former CIO, Marv Adams, sees "learning organization work not only as a way to lead change, but also as a way to build organizations with greater capacity to deal with ongoing change, what he calls 'adaptive organizations'" (as cited in Senge, 2006).

**Recent empirical studies on learning organizations.** A review of recent empirical studies on learning organizations found several recurring themes. The first focuses on the development or validation of tools to measure the degree to which an organization is a learning organization (Abu Khadra & Rawabdeh, 2006; De Villiers, 2008; Marsick & Watkins, 2003; Song, Joo, & Chermack, 2009; Yang et al., 2004). The second attempts to demonstrate a link between learning organizations and performance (Abu Khadra & Rawabdeh, 2006; Moilanen, 2005; Sackmann, Eggenhofer-Rehart, & Friesl, 2009; Yang et al., 2004). These studies were conducted in a variety of organizations within both the private and public sectors worldwide. Only one study focused on the insurance sector (Barkur, Varambally, & Rodrigues, 2007). However, it did not specify whether it was centered on health insurance, which would better fit within the scope of the organizations under study. The study found the philosophy of learning organizations has a positive impact on the quality of service insurance companies deliver.

***Studies focused on tools for assessing learning organizations.*** The studies focused on developing or validating instruments identified 11 tools and approaches to assessing learning organizations. The most frequently cited is the Dimensions of the Learning Organization Questionnaire, which assesses learning organization status at the individual group level in conjunction with organizational performance (Marsick & Watkins, 2003; Moilanen, 2005; Song et al., 2009; Yang et al., 2004). One study, which



incorporated the use of eight separate learning organization assessment tools, demonstrated that all of these tools use Senge's five characteristics of learning organizations in their foundation (Moilanen, 2005).

The premise for this dissertation is that culture is the foundation for organizational behavior. Accordingly, the characteristics of the organization are enabled by the culture. Therefore, studying the culture and considering how that culture qualifies as a learning organization can assist in plans for improving areas that are known to contribute to an organization's ability to learn. Marsick and Watkins (2003), in building the Dimensions of the Learning Organization Questionnaire assessment tool, support this position when they indicate that the most commonly cited aspect of learning cultures including vision, teamwork, and inquiry, alone did not appear to enhance financial performance and must be supported by leadership and an organizational system that supports this type of behavior. In their study developing a maturity model of learning organizations, Chinowsky, Molenaar, and Realph (2007) indicate that a barrier to becoming a learning organization is lack of executive commitment and resource allocation. This constraint speaks to having the right culture, which is set by senior management in allowing learning organizations to evolve. Finally, Carmeli and Sheaffer (2008), in their study on how learning from failure enhances adaptation, recognize the need to foster "a corporate culture conducive to learning" (p. 482). Nonetheless, many of the studies use the term learning organization culture, which implies that the characteristics of learning organizations drive the culture versus the culture enabling these characteristics (Abu Khadra & Rawabdeh, 2006; Chinowsky et al.; Sackmann et al., 2009). Based on the position that culture is the driving factor in enabling a learning organization, this study

will use a cultural assessment tool instead of a learning organization assessment tool. To meet the objective of this research—determining whether health care payment organizations have the necessary culture to facilitate the characteristics of learning organizations, which are adaptable to change—is essential.

***Adaptability to change.*** A common theme in the studies on learning organizations is that they adapt well to change. Chinowski et al. (2007), in their development of a learning organization development model, suggest that learning organizations continually evolve and adapt, which makes them more sustainable. Likewise, Abu Khadra and Rawabdeh (2006), in a study that identifies the steps necessary to become a learning organization in Jordanian industry, provide as their foundation the understanding that learning organizations “demonstrate a capacity to change” (p. 455). In a study of 217 organizations in various industries on how leadership response to failure leads to adaptability, Carmeli and Sheaffer (2008) report that by learning from failures, these organizations “enhanced perceived organizational capacity to adapt to environmental changes” (p. 485). In a case study on public service reform in Tanzania, Issa (2010) found that by adopting the characteristics of learning organizations, the public service organization demonstrated it could change and adapt to meet future needs. Another study recognizing the adaptability of learning organizations was the longitudinal study of a trading company whereby Sackmann et al. (2009) found that adaption of learning organization characteristics helped develop organizations with the capacity to change.

## **Summary**

Change comes in many different forms, but it is a way of life. It involves getting from a current state to a new one, usually in a nonlinear way. The ability to effectively

implement change is predicated on the forces driving the changes versus the ones resisting them. Organizations that have a culture that embraces the characteristics of learning organizations are more adaptable. As health care payment organizations tackle the challenge of health care reform, they will need to understand whether they have a culture that will help or hinder them in this process.

Existing research on learning organizations included suggestions regarding research opportunities for how organizational culture influences learning organizations. For example, De Villiers (2008) proposes inquiry into whether an organization's willingness to learn is the result of its culture. In discussing measuring tools and approaches to assess learning organizations, Moilanen (2005) suggests, "The field is open for various types of analysis and all of them are needed" (p. 87). Finally, Song et al. (2009), in their study validating the use of the Dimensions of the Learning Organization Questionnaire instrument in Korea, advise that further research linking culture and learning organization would be "exciting" (p. 60).

Likewise, several of the studies regarding organizational culture indicated that additional research to understand how culture affects the ability to change and adapt would be beneficial (Fang & Wang, 2006; Fard et al., 2009). Given that no studies on culture or learning organizations were found within the context of health care payment organizations, the focus of this research will contribute to the body of knowledge on both organizational culture and notions of learning organizations and whether they are adaptable to revolutionary change.

### **Chapter 3: Methods**

This chapter explains the research methodology used to determine whether health care payment organizations exhibit the adaptable culture seen in learning organizations. It covers research design, instrumentation, population and sampling procedures, as well as data collection procedures. It also explains how human subject considerations adhered to the principles of ethical research.

#### **Research Design**

The goal of this study was to determine the existing culture of health care payment organizations and their readiness to become learning organizations that best adapt to change. In prior chapters, evidence was presented that learning organizations adapt better to change. According to Kotter (1996), in his book dealing with how to overcome resistance to change, the culture of adaptable organizations is “externally oriented, empowering, quick to make decisions, open and candid, more risk tolerant” (p. 172). Essentially, learning organizations possess similar traits to adaptable organizations and adaptable organizations possess specific cultural characteristics. Through the capture of survey data, an analysis of the current culture of health care payment organizations was assessed to determine whether their cultures were in line with the culture of learning organizations. The expectation was that if findings revealed that the selected organizations are poised as learning organizations, then health care payment organizations may be better able to adapt well to the revolutionary changes such as health care reform. Two specific research questions were addressed:

1. What are the perceptions of experienced individuals within the health care payment segment of the industry regarding the current organizational culture

as measured by their organizations' Dominant Characteristics, Organizational Leadership, Management of Employees, Organization Glue, Strategic Emphases, and Criteria of Success presented in the OCAI?

2. How aligned are these health care payment organizations with characteristics of learning organizations?

**Population and sample.** Health care reform will affect all types of commercial health care administration organizations, including government sponsored plans, medical providers, employers, health care insurers, pharmaceutical companies, medical equipment providers, and the many organizations that support these entities. Because of the scope of organizations impacted by this change, it was not practical to sample all of these diverse populations. Therefore, for purposes of this study, the targeted population was employees, typically in mid- to senior management or key staff positions, whose organizations are impacted in some manner by the recent health care reform mandate and work for the following types of organizations:

- Commercial health care insurance companies
- Self-insured employers and third-party administrators that administer the benefit plans for these employers
- Health care consultants who provide direction to employers on how to manage their health care benefits
- Cost management organizations who assist employers and insurance companies in managing medical costs
- Technology companies that support these organizations.

Since health care reform is national in scope, no exact listing of all possible target population members is possible. Thus, a nonprobability sampling in which Bryman and Bell (2003) explain, “some units in the populations are more likely to be selected than others” (p. 93) was selected. This sampling targeted participants known through my own professional contacts within the industry and relied on network sampling to select survey participants. Participants were asked to complete a survey and to encourage qualified colleagues within their professional networks also to participate in the study, which resulted in several additional participants.

There were several reasons for selecting a nonprobability sampling method for this study. First, there are more than 1,000 organizations in the health payment systems segment of the industry (America’s Health Insurance Plans, 2011; Hoovers, 2012). Each of these organizations employs from a handful to tens of thousands of employees. Therefore, the potential target population for this study, which Bryman and Bell (2003) explain is “the universe of units from which the sample is to be selected” (p. 93), numbers in the hundreds of thousands of individuals. Short of getting the personnel rosters and contact information for each of the individuals who work for these organizations, which was not possible or efficient, there was no way to identify the elements of the population. Second, this study focuses on adaptability to revolutionary change and required the participants of this study to have direct experience dealing with major change, most specifically, the impact of health care reform. To identify these individuals required knowledge of their roles and responsibilities. Finally, for individuals to be willing to complete a survey that addresses the culture within their organizations required that they feel comfortable sharing this knowledge. To achieve the high level of

participation required an element of trust, which relies on established personal and professional relationships. Anderson and Kanuka (2003), in their book on e-research, advise, “Trust can be established between the e-researcher and the participants by establishing both personal and institutional credibility” (p. 154). Using a broad network of contacts, surveys were sent to 138 qualified professionals employed by a variety of health payment system organizations nationwide. Further, these individuals were requested to disseminate the request for participation to qualified participants. This approach resulted in 106 completed surveys across all targeted business segments. The only utilized sampling criteria was that the participant had to be employed by a health care payment organization in one of the target segments in a management or key staff capacity, consider themselves familiar with the organization’s culture for which they are currently working, and were willing to complete the online survey instrument. To have a sense of confidence that the sample represented the targeted population, responses from roughly 60 participants were originally sought. Having almost twice that number of responses indicated a strong interest by the individuals within the targeted population.

**Data collection strategy.** Electronic surveys, using a web-embedded survey, provided the data for this study. Communication with possible participants relied mostly on electronic communications. Some telephone or face-to-face connections occurred though cultural data was collected using an encrypted web-based survey tool.

**Surveys.** An electronic survey tool was used to capture information from a network of individuals. There are thousands of health care payment organizations in the United States that employ hundreds of thousands of individuals. It was not time or cost effective to attempt to gather information from all these entities. However, surveys

provided a means to target a specific sample, which Babbie (1990) states serves the purpose of “understanding the larger population from which the sample was initially selected” (p. 42). Therefore, surveys provided a sound and practical method for exploring whether health care payment organizations are adaptable to revolutionary change.

*Web surveys.* The individuals who work for health care payment organizations in management or key staff roles have access to electronic communication. This was the same population that was targeted for this study. Consequently, it was practical to use a web survey, which Ma and McCord (2007) define as “a type of survey using Web technology and server-client architecture” (p. 18) to reach this population. In a publication dealing with the opportunities and constraints of electronic research, Roberts (2007) advises that when considering the use of electronic research, “the first consideration is whether the population of interest can be ‘captured’ through electronic recruitment...where access is required to a hidden/specialized population, it may prove ideal” (p. 24). This study sought the opinions of a specific subset of qualified health care payment organization personnel, all of whom routinely use electronic communication. Therefore, the use of an e-survey lent itself well to this research project.

Bryman and Bell (2003) state a web survey operates “by inviting prospective respondents to visit a web site at which the questionnaire can be found and completed online” (p. 508). There are several advantages to web surveys. These include lower cost, which allows for a broader sample; speed in disseminating the surveys and obtaining results; and the ability to insert responses directly into the databases used for computation, which is economical and reduces the potential for data entry errors (Anderson & Kanuka, 2003; Madge and Manfreda as cited in Fleming & Bowden, 2007;



Jansen, Corley, & Jansen, 2007; Roberts, 2007). Additionally, web-based questionnaires allow for built-in controls to assure the respondent follows instructions (Fleming & Bowden, 2007). The most commonly cited disadvantages of web-based surveys are the technical challenges, sample frame, poor response rates, and lack of control over the research setting (Anderson & Kanuka, 2003; Manfreda, 2001, as cited in Fleming & Bowden, 2007; Jansen et al., 2007; Roberts, 2007). Because of the nature of their jobs, the survey participants all had access to computers and were familiar with web-based applications. Therefore, these commonly cited concerns did not apply in this instance. Additionally, the web-based survey tool was tested by five individuals who were not study participants prior to distribution to assure its functionality was optimized. Another noted potential issue with web surveys Fleming and Bowden (2007) cite is the potential for “several respondents at one computer address...or one respondent from a variety of computers” (p. 285) answering the survey. The survey for this study was hosted on SurveyMonkey, a commercially available provider of web-based surveys. The SurveyMonkey tool prevented multiple responses from the same respondent by allowing only one response per computer. This feature was tested prior to the survey dissemination to assure this restriction worked as expected. Therefore, this concern was mitigated through the setup of the survey. Based on the sample of participants for this study and the high response rate, the web surveys provided a practical approach that was consistent with the tools these individuals interact with regularly. This familiarity with the mode of administration may well have been a contributing factor to the high level of participation. A single demographic item about the type of organization was collected to enable some subgroup analysis.

**Instruments to assess organizational culture.** In the review of the literature, numerous surveys were identified that assess organizational culture (Ashkanasy et al., 2000; Jung et al., 2009). Since culture lays the foundation for the behavior of the organization, it can be used to establish whether organizations demonstrate the characteristics of learning organizations that adapt well to revolutionary change. Therefore, utilizing a cultural survey that reveals the culture of health care payment organizations was an appropriate approach to assess whether these organizations are learning organizations and, hence, adaptable. In order to explore the question of whether health care payment organizations are learning organizations that can adapt to revolutionary change, an organizational culture assessment survey was utilized. Several of the cultural assessment tools result in a description of various types of culture.

Learning organizations demonstrate a culture that is:

- Externally oriented and recognizes the importance of systems thinking
- Empowering and less bureaucratic
- Quick to make decisions
- Open and candid
- More risk tolerant
- Focused on learning and improvement
- Possesses a shared vision (Kotter, 1996; Marquardt, 2002; Senge, 2006).

Hence, a culture type that demonstrates these characteristics would indicate that the organization is a learning organization. Cameron and Quinn (2006), in the OCAI, categorize organizational culture into four profiles. Two of these profiles, *Clan* and *Adhocracy*, reflect characteristics of learning organizations. These two profiles align well

with the cultural characteristics of learning organizations, making the OCAI an excellent fit for this research, which establishes whether the respondents perceive their organizations demonstrate the culture of learning organizations. Other reasons for the selection of the OCAI included:

1. It is user friendly and was easily adaptable to a web survey format, which was designed to assure that the individual responses tabulate appropriately.
2. The authors provide precise instructions for scoring the answers and plotting them into a matrix that reflects the level of cultural fit in each of the four cultural profiles. This allows for the measure of whether health care payment organizations are learning organizations and how strongly they reflect or deviate from the characteristics of these types of organizations.
3. It has been used by thousands of organizations, including insurance companies and found to have a high degree of validity.
4. Permission to use the tool was obtained (Appendix B).

**OCAI.** Cameron and Quinn (2006) developed the OCAI, which organizations can use to assess their cultures. This survey is based on “a theoretical model known as the *Competing Values Framework*” (p. 31). This framework assesses organizational effectiveness using two dimensions. The first dimension differentiates effectiveness criteria that emphasize flexibility, discretion, and dynamism from criteria that emphasize stability, order, and control. The second dimension differentiates effectiveness criteria that emphasize an internal orientation, integration, and unity from criteria that emphasize an external orientation, differentiation, and rivalry.

The OCAI consists of six sections with four questions in each section (Appendix C), which are used to determine where the survey participants' organizations lie within the two dimensions and the four culture profiles. The respondents divide the score for the four questions in each section so that the sum of the answers equals 100 in that section with the goal of illustrating which culture in that section is strongest within the organization. The scores are summarized using a worksheet that depicts the selected culture for each section from preferred to least desirable (Cameron & Quinn, 2006). The results are then plotted to determine the culture that dominates the organization, and the strength of that culture. There are four possible resulting cultural profiles:

1. The *Clan* culture, which demonstrates an organization that focuses on internal maintenance with flexibility, concern for people, and sensitivity to customers.
2. The *Adhocracy* culture, which focuses on external positioning with a high degree of flexibility and individuality.
3. The *Hierarchy* culture, which demonstrates a focus on internal maintenance with a need for stability and control.
4. The *Market* culture, which reflects a focus on external positioning with a need for stability and control.

The OCAI survey is designed to have the respondents take the survey twice. The first time the responses are based on how the organization currently operates. The second time the respondents indicate what the preferred measurement would be for the organization to adapt best to a new environment. Since the purpose of this study was to determine whether health care payment organizations are presently learning organizations, the respondents were only asked to answer the first (current) component of

the survey, which assesses the existing culture. The responses were used to determine which culture profile(s) best illustrates the health care payment organizations of the individuals at the time of the survey.

*Reliability and validity.* Cameron and Quinn (2006) advise that the OCAI has been used extensively and has been found to be both reliable and valid. The authors cite several studies supporting the validity of their tool. These include a study of 796 executives from 86 public utilities, spanning top managers to line and staff employees. In this instance, the Cronbach alpha coefficient were statistically significant for each of the culture profiles within the instrument—.74 for the *Clan* culture, .79 for the *Adhocracy* culture, .73 for the *Hierarchy* culture, and .71 for the *Market* culture. Likewise, a high degree of validity was found using the Cronbach alpha coefficient in a study of 10,300 executives in 1,064 businesses—.79 for the *Clan* culture, .80 for the *Adhocracy* culture, .76 for the *Hierarchy* culture, and .77 for the *Market* culture. The authors inform us that numerous other studies are available all supporting the reliability of the instrument and demonstrating that this tool “matches or exceeds the reliability of the most commonly used instruments in the social and organizational sciences” (p. 154).

To demonstrate that the OCAI really measures the four types of organizational cultures, Cameron and Quinn (2006) reference a study of 334 institutions of higher education in which they found strong evidence for concurrent validity. The authors also cite evidence for convergent and discriminant validity, which were tested using multitrait-multimethod analysis and a multidimensional scaling analysis. Further evidence of validity was offered in a study of college cultures. Cameron and Quinn indicate further studies were conducted and that they are not aware of any that disconfirm

the validity of the tool. Accordingly, the authors note, “The empirical evidence suggests that the OCAI measures what it claims to measure...in a reliable way” (p. 160).

*Response scale.* The OCAI uses an ipsative rating scale with which the respondents divide 100 points among the questions. Cameron and Quinn (2006) indicate two advantages to this approach over the commonly used Likert scale: The first is that it demonstrates the uniqueness in the culture between organizations, and second, it makes the respondents aware of the trade-offs organizations need to make.

### **Human Subjects Considerations**

This research adhered to the commonly recognized principals for ethical research, which include voluntary participation, beneficence, as well as anonymity and confidentiality of data. Pepperdine University adheres to the federal standards for conducting any research that involves human subjects. The emergence of electronic research creates a need to assure that these well-recognized parameters are preserved in this new environment. Gurau (2007) suggests “a good starting point in creating ethical principles adapted for online surveys is the existing principles applied for classical research projects” (p. 114). Anderson and Kanuka (2003) expand on the use of established principles by e-researchers when they indicate they should,

...begin the search for ethical guidelines in the more familiar offline context, apply those ethical constraints that make sense and are doable in the online world, and then proceed cautiously, openly, and honestly, in new research domains as they are presented. (p. 71)

The e-mail to individuals inviting them to participate in the survey (Appendix D) advised the recipients of the purpose of the study and provided a link to the survey along

with instructions on how to complete the survey (Appendix E). The invitation explained the potential risks and benefits of participation and made it clear that participation is voluntary. These potential risks were considered minimal and included loss of some time and possible boredom in completing the survey process. There was no direct benefit to the subjects for participation. However, assisting the health care payment systems industry in figuring out how to adapt to change may have provided some personal satisfaction.

One additional potential participant concern that could have surfaced with use of the web survey was that the respondent's identity could be revealed. Since the respondents were providing insight into their organizations' behavior, they might have been concerned that their organizations would object to their participation or take issue with the publication of their response. Anderson and Kanuka (2003) make the distinction between confidentiality and anonymity when they explain, "With anonymity, steps are taken by the researcher to insure that the participants' identities are not revealed to the researchers...whereas with confidentiality, the researcher does know the participants identities...but takes steps to keep their identities confidential" (p. 61). SurveyMonkey, which hosted the survey, maintained the anonymity of the respondents and information such as IP address or e-mail address was not collected. This approach assured the anonymity of the respondents and of their organizations. In the unlikely event a participant's identity had been revealed, it would not place the subject at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation. Only aggregate data is reported in this study. SurveyMonkey compiled the responses in spreadsheets and deidentified individual surveys, which could be accessed

only by the researcher using her account login and password. The response data was maintained by SurveyMonkey in a personal password-protected account accessible exclusively to the researcher. Such data was extracted onto the researcher's computer on an external hard drive, which is password protected and kept in a locked personal environment. Only the researcher has access to the data with limited, controlled access granted as necessary to a statistician and/or the research advisor. At the completion of the study, a single copy of survey response data was stored electronically on a password-protected external hard drive in a locked personal environment in the researcher's home where it will be retained for 5 years. Likewise, only a single copy of any necessary hard copy data will be maintained and stored for 5 years in a locked personal environment in the researcher's home. At that time, survey results will be deleted from SurveyMonkey and from the researcher's external hard drive by the researcher.

Finally, the invitation to participate identified the researcher and the university where the research was being conducted as well as explained the purpose of the research, articulated participant expectations, addressed risks and benefits, explained how privacy would be maintained, and provided the researcher's contact information for further questions (Anderson & Kanuka, 2003; Gurau, 2007). The invitation to participate met the requirements of informed consent, which Gurau (2007) defines as "consent given by the participants to an online survey only after achieving an understanding of the research project context, and of the consequences or risks involved" (p. 119).

This research met criteria for being considered exempt from full or expedited review based on Federal Guidelines 45 CFR 46.101(b)(2). Prior to launching the research, an application for exemption as well as a waiver for documentation of



information consent was submitted to and granted by the Pepperdine University Graduate & Professional Schools Institutional Review Board (Appendix F).

### **Data Collection Procedures**

The data collection process consisted of the following steps:

1. Permission to use the OCAI and adapt it for electronic use was obtained (Appendix B).
2. Demographic items and OCAI items were drafted into an electronic format.
3. An Application for a Claim of Exemption and an Application for Waiver of Documentation of Informed Consent was submitted to and granted by the Pepperdine University Graduate & Professional Schools Institutional Review Board (Appendix F).
4. A pilot study with five participants was conducted. None of these individuals participated in the research survey. The purpose of the pilot was to insure the survey operated as anticipated, to determine the time necessary to complete the survey, and to validate the clarity of the instructions. The first step was to call these individuals to determine their willingness to participate in the pilot process. All contacted individuals agreed to participate. Following their agreement, each participant was sent an e-mail (Appendix G) outlining the items that needed to be tested, the survey tool, and an assessment form (Appendix H). These individuals were computer literate with experience in taking online surveys. Their insights were used to advise the sample participants that the estimated time needed to complete the survey was

approximately 10 minutes. These individuals also validated that the survey worked as anticipated and that the instructions were clear.

5. Concurrent with the pilot study, in an effort to enhance communication and maximize the survey response rate, five industry colleagues were asked for input regarding suggestions to improve the survey participation request. Their input was assessed and incorporated as appropriate.
6. Invitations to participate in the study were launched following Institutional Review Board approval. The invitation to participate was sent via e-mail to a list of 138 qualified participants. This communication requested that these individuals complete the survey within a 16-day period. This request for participation also invited them to forward the survey participation request and survey link to other qualified individuals (Appendix D). Since the list of participants asked to participate in the survey was composed of industry colleagues, personal communication verbally and electronically often occurred ahead of time to let them know they would be receiving an e-mail asking for their participation in this doctoral research project. Citing a Gilbert study, Anderson and Kanuka (2003) indicate, “that as many as 85 percent of users, at least occasionally, delete messages without reading them” (p. 151). By providing potential participants with advance knowledge of the upcoming request, an increased awareness of the upcoming request might have contributed to the high response rate. None of the individuals who were contacted indicated they did not want to be included in the distribution.

7. Thirteen days following the distribution of the initial invitation to participate, a reminder e-mail was sent to the candidates on the initial distribution list, asking them to complete the survey within the next 10 days if they had not done so already (Appendix I).
8. The initial goal was to obtain at least 60 completed surveys. Since 106 completed surveys were obtained within the planned data collection time period (August 27, 2011 and September 19, 2011), no further network sampling was needed to obtain an acceptable number of responses.

### **Analysis**

As surveys were completed, the data were gathered from Survey Monkey. Data were scored using the Worksheet for Scoring OCAI (Cameron & Quinn, 2006). Each average score was plotted in the Organizational Culture Profile Form. Using the demographic data captured (type of organization), some subgroup analysis was also performed. Once all the average scores were plotted, patterns emerged indicating what the respondents believe the prevailing culture was within their organization. The data reflected whether the industry and specific segments within demonstrated the characteristics of learning organizations, reflected in the *Clan* and *Adhocracy* cultures, which better adapt to revolutionary change.

### **Summary**

The goal of this research was to understand better the culture of health care payment organizations to assess their alignment with characteristics of learning organizations that best adapt to revolutionary change. This quantitative study used a web-based survey strategy to capture data from individuals working within organizations

involved in the administration of the payment reimbursement practices for the health care industry.

## **Chapter 4: Results**

The purpose of this study was to determine the current culture of health care payment system organizations to assess for characteristics of learning organizations considered best for adapting to revolutionary change. The research questions were:

1. What are the perceptions of experienced individuals within the medical reimbursement segment of the industry regarding their current organizational culture as measured by the organization's six core attributes—Dominant Characteristics, Organizational Leadership, Management of Employees, Organization Glue, Strategic Emphases, and Criteria of Success—that define the OCAI's four culture profiles?
2. How aligned are these health care organizations with characteristics of learning organizations?

The OCAI (Cameron & Quinn, 2006), which assesses organizational culture, was used to capture measurable data for this study. This chapter presents a description of the study participants and the culture profile of the overall health care payment industry, including details about each of the six core attributes within the Cameron and Quinn model. To address the second research question, the chapter includes an explanation of how this culture profile aligns with the characteristics of learning organizations. This chapter also reflects the culture profiles by industry segment and concludes with a summary of key findings.

### **Description of Study Participants**

A nonprobability network sampling method was used to identify survey participants. Participants had to be actively employed by a health care payment

organization in a key role, have at least 5 years of industry tenure, and be familiar with the culture of their organization. Using these criteria, a request for participation e-mail (Appendix D) was forwarded to 138 individuals in 79 organizations. These organizations included Insurance Companies, Third-Party Administrators (TPA), Preferred Provider Organizations (PPO), Self-Insured Employers, Health Care IT Systems Vendors (IT Vendor), Cost Management Organizations, Health Benefits Consultants (Consultant), Other types of companies in this sector, and organizations serving Multiple segments of the industry, all within the commercial sector of the health care payment system. A reminder e-mail (Appendix I) was sent to the same list of participants 13 days following the initial request for participation. In some cases the initial targeted list of participants forwarded the survey to other qualified individuals within the industry. Three weeks following the initial request for participation, the survey was closed with a total of 106 completed surveys.

The survey was structured to require respondents to identify at least one type of organization within the industry for which they worked. If the participant's organization was involved in more than one segment of the industry, the respondent was asked to identify all applicable segments. Of the 106 responses, 21 (20%) indicated their organization served more than one segment of the industry. In these instances, the participants' scores were aggregated into a category designated as Multiple. Appendix J reflects the industry segments within the Multiple category. In some cases where the participant selected the Other category but the industry description aligned well with one of the predefined categories, the results were reallocated accordingly. If the description was unique such as "overall plan administrator" or "well-being improvement," a decision

was made as to where best to place the participant response. Where the organization descriptions demonstrated distinctive functions that did not fit into a preassigned category such as for “prescription benefit managers” and “reinsurance companies,” these were kept in the Other category.

The distribution of responses from the 106 completed surveys (see Table 1 and Figure 2) reflects that the largest percentage of respondents came from Cost Management Organizations ( $n = 31$ ; 29%). The next closest category was the Multiple segment ( $n = 21$ ; 20%) followed by the PPO industry ( $n = 14$ ; 13%). The TPA ( $n = 11$ ; 10%) and Insurance Companies ( $n = 10$ ; 9%), which clustered closely, were the next largest segments.

Table 1

*Number of Responses by Industry Segment*

Industry Segment	Responses ( $N = 106$ )	Percentage
Insurance Company	10	9%
Third-Party Administrator (TPA)	11	10%
Self-Insured Employer (Employer)	5	5%
Health Benefits Consultant (Consultant)	6	6%
Preferred Provider Organization (PPO)	14	13%
Cost Management Organization	31	29%
Health Care IT Systems Vendor (IT Vendor)	4	4%
Other	4	4%
Multiple Segments	21	20%
Total	106	

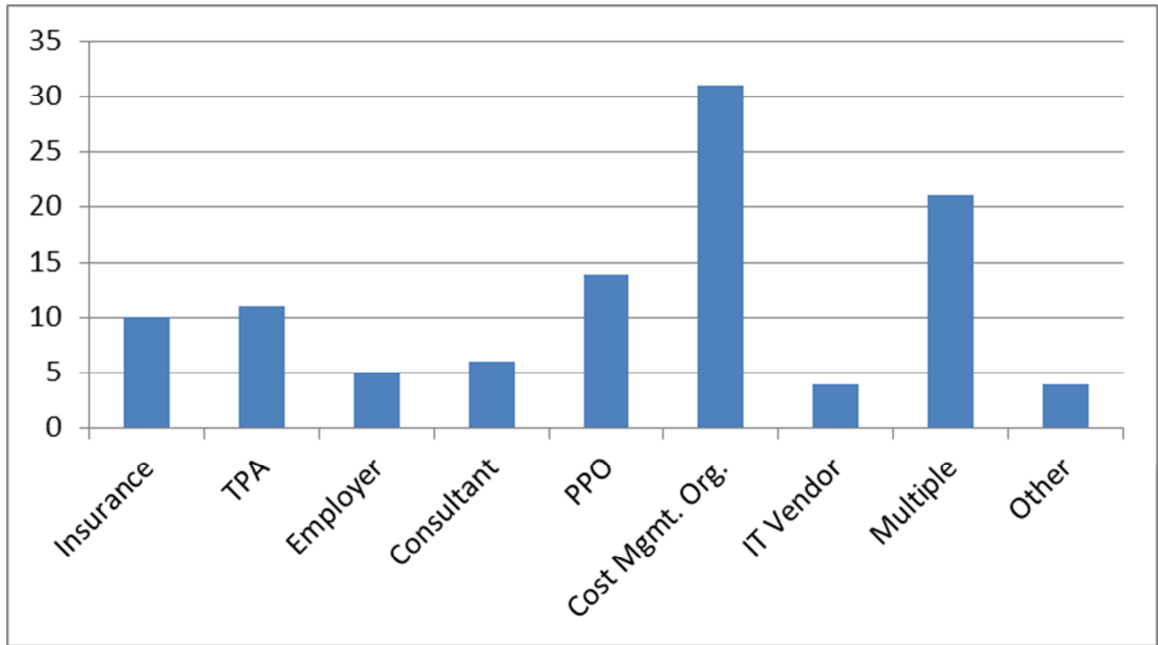


Figure 2. Displays the number of responses by type of organization ( $N = 106$ ).

The study resulted in participation from all identified industry segments as well as responses from some other business entities within the health care payment industry.

### **Culture Profile of the Overall Health Care Payment Industry**

The OCAI consists of six core attributes with four possible choices within each attribute. The individual respondent distributes 100 points among the four items within each attribute. Each item corresponds to one of four culture types: *Clan* (A), *Adhocracy* (B), *Market* (C), and *Hierarchy* (D). A higher point score indicates a more pronounced or dominant culture. The suggested threshold for determining a culture to be predominant is 10 points (Cameron & Quinn, 2006). An overall culture score is determined by considering the culture type scores for each of the six core attributes. When core attributes are aligned, the same patterns apply to each of the six core attributes and the resulting graphics mirror each other in each of the six areas.

Cameron and Quinn (2006) provide a model to build a picture of the



organizational culture data. The resulting figure provides a graphic depiction of the most and least dominant cultures. Using the average scores for each alternative culture (A, B, C, D), the authors instruct plotting the numbers on a diagonal line within the quadrants illustrating the four alternative cultures. The resulting figure can be used to view the culture profile for the overall industry, for each business segment, or to determine whether the six core attributes are aligned.

The culture of the organizations represented by the 106 individuals in this study showed almost an equivalent dominance of two cultures: The *Market* culture (score = 28) and the *Clan* culture (score = 27). The *Hierarchy* culture (score = 21) was least dominant for this sample of organizations. Cameron and Quinn (2006) advise that differences of 10 points or more in culture profiles are notable. Using this criteria, the data for the industry overall, as reflected in Table 2, demonstrates that culture scores for the four culture profiles did not vary beyond the model's suggested 10-point variation. These findings indicate that no single culture type strongly prevails within the industry.

Table 2

*Overall Culture Profile of Participants' Organizations*

Culture Profile	Average Score
Clan (A)—An organization that focuses on internal maintenance with flexibility, concern for people, and sensitivity to customers.	27
Adhocracy (B)—An organization that focuses on external positioning with a high degree of flexibility and individuality.	23
Market (C)—An organization that focuses on external maintenance with a need for stability and control.	28
Hierarchy (D)—An organization that focuses on internal maintenance with a need for stability and control.	21

*Note.*  $N = 106$

When the culture profile is graphed (see Figure 3) for the overall industry, the image supports the findings that while the *Market* and *Clan* cultures are strongest, no single culture type strongly dominates the industry.

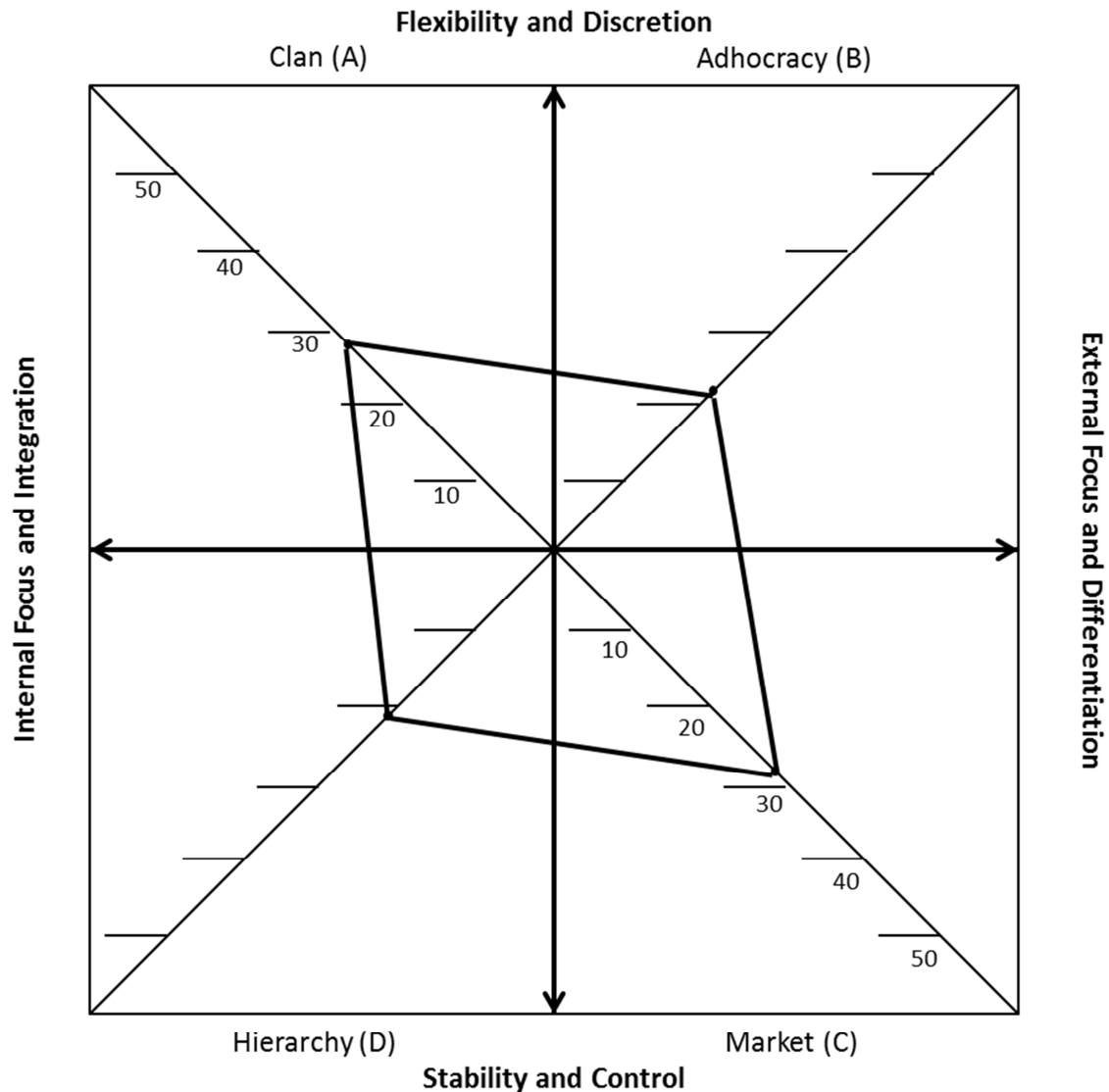


Figure 3. Culture profile of the total sample ( $N = 106$ ). From the plot framework in *Diagnosing and Changing Organizational Culture* (p. 55), by K. S. Cameron and R. E. Quinn, 2006, San Francisco, CA: Jossey-Bass. Copyright 2006 by John Wiley & Sons, Inc. Adapted with permission.

When core attributes are aligned, the same culture patterns apply to the six core attributes (Cameron & Quinn, 2006) and the resulting figures mirror each other for the

six core attributes. A review of the scores for the six organizational attributes for the overall industry is presented in Table 3. This data indicates that the *Market* culture scored highest in three of the six categories: Dominant Characteristics, Organizational Leadership, and Criteria of Success. The *Market* culture was tied for top score with the *Clan* culture for Strategic Emphases. The *Clan* culture scored highest for Management of Employees and Organization Glue.

Table 3

*Culture Profile Scores of the Total Sample by Cultural Attributes*

Culture Profile	Dominant Characteristics	Organizational Leadership	Management of Employees	Organization Glue	Strategic Emphases	Criteria of Success
Clan (A)	28	20	34	34	26	22
Adhocracy (B)	25	27	21	21	24	22
Market (C)	29	30	24	28	26	33
Hierarchy (D)	18	23	21	17	24	22

*Note.*  $N = 106$ . Highest score for each characteristic is shaded.

When the culture profile by cultural attribute is graphed (see Figure 4 and Appendix K) it clearly reveals the variance in dominant cultures between the core attributes. This lack of alignment among core attributes can create obstacles in organizations or, in this case, to the overall industry's effectiveness (Cameron & Quinn, 2006). Additional data reflecting the cultural patterns underlying the four culture profiles for the overall industry ( $N = 106$ ) are presented in Appendix L. The table presented in this appendix provides the average scores for each question within the six core attributes for the overall industry as well as for each industry segment.

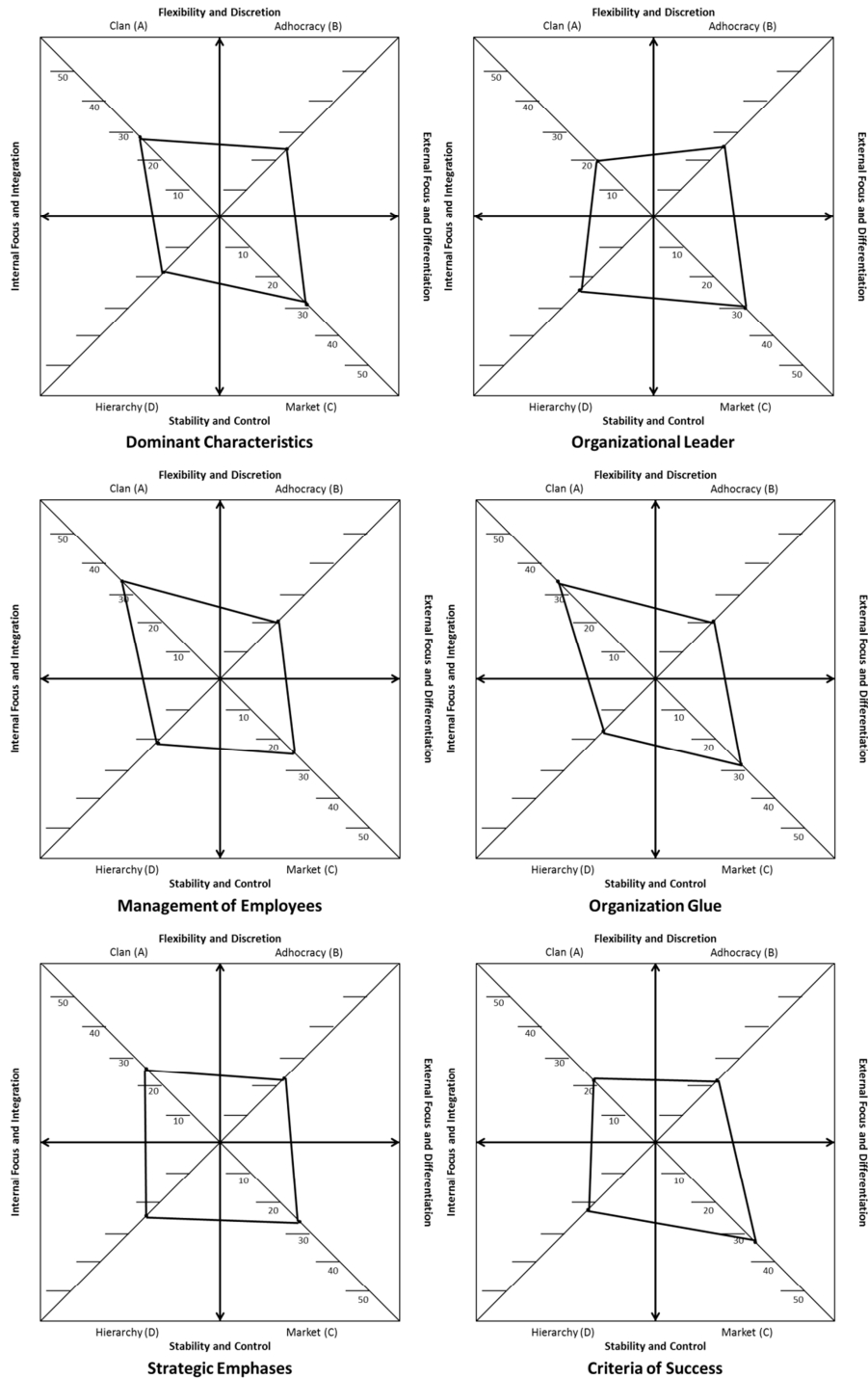


Figure 4. Culture profile of the total sample by cultural attributes ( $N = 106$ ). From the plot framework in *Diagnosing and Changing Organizational Culture* (p. 76), by K. S. Cameron and R. E. Quinn, 2006, San Francisco, CA: Jossey-Bass. Copyright 2006 by John Wiley & Sons, Inc. Adapted with permission.

A review of the data in Appendix K provides additional insight into which of the four culture types are more dominant within each core attribute both on an overall basis for the industry and by industry segment. These data inform us on the industry culture and the characteristics that define it both overall and by industry segment, indicating that the attributes have different culture profiles.

### **Health Care Payment Organizations as Learning Organizations**

The characteristics of learning organizations are most strongly reflected in the *Clan* and *Adhocracy* cultures, and a combined score for these two culture profiles was calculated. This combined score is labeled as a Learning Organization score. Whereas the combined score for the *Hierarchy* and *Market* cultures, which do not reflect the characteristics of learning organizations, is labeled as a Nonlearning Organization score.

**The industry as a learning organization.** Table 4 compares the overall industry's Learning Organization score (50) to its Nonlearning organization score (49). This data reveals that the scores are nearly even in both categories. Therefore, the health care payment industry is not driven by a dominant learning organization culture.

Table 4

*Overall Culture Profile of Participants' Organizations Comparing Clan and Adhocracy Culture Combined Scores (Learning Organization) to Hierarchy and Market Culture Combined Scores (Nonlearning Organization)*

Learning Organization	Culture Profile	Score
	Clan (A)	27
	Adhocracy (B)	23
	Total	50
Nonlearning Organization	Culture Profile	Score
	Market (C)	28

(continued)

Nonlearning Organization	Culture Profile	Score
	Hierarchy (D)	21
	Total	49

*Note.*  $N = 106$ . Combined *Clan* and *Adhocracy* cultures represent Learning Organizations. Combined *Market* and *Hierarchy* Cultures represent Nonlearning Organizations.

**Industry segments as learning organizations.** While the industry overall does not reflect a learning organization culture or any other distinctive pattern, looking at the data by industry segment (Table 5) reveals that some industry segments, such as Consultants (Learning Organization Score = 69), organizations in the Other category (Learning Organization Score = 58), and Cost Management Organizations (combined Learning Organization Score = 54), are better aligned with learning organization culture. These demonstrate a higher Learning Organization score than other industry segments.

Table 5

*Culture Profile of Participants' Organizations Comparing Learning Organization Scores to Nonlearning Organization Scores*

Culture Profile	Insurance Company $n = 10$	TPA $n = 11$	Employer $n = 5$	Consultant $n = 6$	PPO $n = 14$	Cost Management Vendor $n = 31$	IT Vendor $n = 4$	Other $n = 4$	Multiple $n = 21$
Clan (A)	26	28	33	26	31	25	28	30	27
Adhocracy (B)	23	21	17	33	17	29	19	28	20
Learning Organization	49	49	50	69	48	54	47	58	47
Market (C)	30	27	24	28	28	29	31	31	28
Hierarchy (D)	21	24	25	14	25	17	22	12	26
Nonlearning Organization	51	51	49	42	53	46	53	43	54

*Note.*  $N = 106$ . Combined *Clan* and *Adhocracy* cultures represent Learning Organizations. Combined *Market* and *Hierarchy* cultures represent Nonlearning Organizations. Highest culture profile scores for each segment are lightly shaded and the highest combined scores are darkly shaded.

## Culture Profile by Organization Type

The health care payment systems industry consists of multiple industry segments involved in the administration, payment, and cost management of medical claims. For this study, the data were captured to reflect responses within specific industry segments: Insurance Companies, TPA, Self-Insured Employers (Employer), Health Benefits Consultants (Consultant), PPO, Cost Management Organizations, Health Care IT System Vendors (IT Vendor), and a catch-all category labeled Other. There were 21 participants who indicated their organizations were involved in multiple segments. To capture the unique nature of these responses, an industry segment of Multiple was created.

The average culture scores and resulting culture profiles indicate that the *Market* culture dominates in four of the eight industry segments: Insurance companies, IT Vendors, Other, and Multiple. The *Clan* culture dominates the TPA, Employer, and PPO segments, while the *Adhocracy* culture is emphasized for Consultants and tied with the *Market* culture for the Cost Management Organization segment (see Table 6).

Table 6

### *Culture Profile of Participants' Organizations by Industry Segment*

	Clan (A) Focuses on internal maintenance with flexibility, concern for people, and sensitivity to customers	Adhocracy (B) Focuses on external positioning with a high degree of flexibility and individuality	Market (C) Focuses on external positioning with a need for stability and control	Hierarchy (D) Focuses on internal maintenance with a need for stability and control
Insurance Company <i>n</i> = 10	26	23	30	21

(continued)

	Clan (A) Focuses on internal maintenance with flexibility, concern for people, and sensitivity to customers	Adhocracy (B) Focuses on external positioning with a high degree of flexibility and individuality	Market (C) Focuses on external positioning with a need for stability and control	Hierarchy (D) Focuses on internal maintenance with a need for stability and control
TPA <i>n</i> = 11	28	21	27	24
Employer <i>n</i> = 5	33	17	24	25
Consultant <i>n</i> = 6	26	33	28	14
PPO <i>n</i> = 14	31	17	28	25
Cost Management Vendor <i>n</i> = 31	25	29	29	17
IT Vendor <i>n</i> = 4	28	19	31	22
Other <i>n</i> = 4	30	28	31	12
Multiple <i>n</i> = 21	27	20	28	26

*Note.* *N* = 106. Highest scores in each segment are shaded.

Each industry segment has a unique culture profile. While many of these segments do not show pronounced differences, segments such as the Consultants and Cost Management Organizations demonstrate a stronger *Adhocracy* culture. Likewise, Employers, PPOs, TPAs, and the Multiple segment demonstrate a stronger *Hierarchy* culture than other segments within the industry (see Figure 5 and Appendix M).

Overall, the health care payment industry has a distributed culture profile with slightly higher scores for the *Market* and *Clan* cultures. However, unique culture profiles exist within each of the segments of the industry.



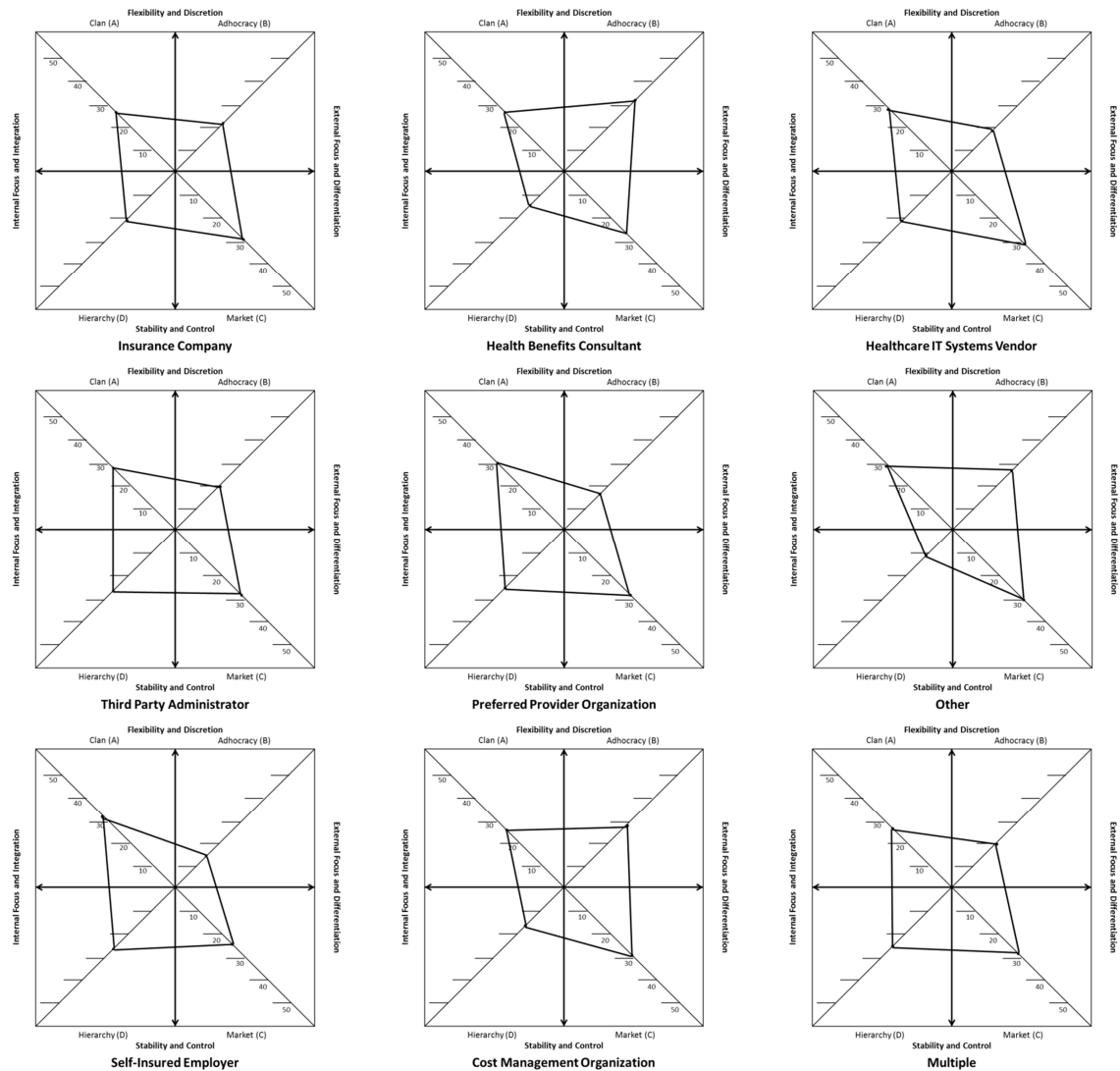


Figure 5. Culture profile by industry segment ( $N = 106$ ). From the plot framework in *Diagnosing and Changing Organizational Culture* (p. 77), by K. S. Cameron and R. E. Quinn, 2006, San Francisco, CA: Jossey-Bass. Copyright 2006 by John Wiley & Sons, Inc. Adapted with permission.

### Differences in Culture Attributes Within Two Industry Segments

The largest numbers of responses were received from participants employed by Cost Management Organizations and in the Multiple segment. Therefore, there is an opportunity to obtain additional insight into the attributes that constitute the culture profiles of these two segments. Considering that the Cost Management industry displays a Learning Organization culture while the Multiple industry does not (see Table 5), a

further exploration of the six cultural attributes of these organizations can inform us on the behaviors that create the different culture profiles reflected by these two segments.

**Culture attributes for the Cost Management Organization segment.** The Cost Management Organizations represented the largest single business segment within this study and demonstrated a Learning Organization culture profile. For those reasons, additional review of their data is warranted. Culture scores for the six cultural attribute categories are presented in Table 7. This data reveals that the dominant culture profile varies among the six attributes. Figure 6 and Appendix N demonstrate the different patterns for Management of Employees and Organization Glue as compared to the culture profile for Organizational Leadership and Strategic Emphases, and Criteria of Success and Dominant Characteristics. The data in Table 7 reveal that for this industry sector the Learning Organization Score prevails in four of the six attributes. In the two attributes where the Nonlearning Score is higher, the difference in the two combined culture scores is only two points—51 versus 49.

Table 7

*Cultural Attribute Culture Profile for Cost Management Organizations*

	Clan (A)	Adhocracy (B)	Learning Organization Score	Market (C)	Hierarchy (D)	Nonlearning Organization Score
Dominant Characteristics	28	29	57	31	12	43
Organizational Leadership	17	32	49	30	21	51
Management of Employees	32	26	58	23	18	41
Organization Glue	34	26	60	27	14	41

(continued)

	Clan (A)	Adhocracy (B)	Learning Organization Score	Market (C)	Hierarchy (D)	Nonlearning Organization Score
Strategic Emphases	21	31	52	28	21	49
Criteria of Success	20	29	49	36	15	51

*Note.*  $n = 31$ . Combined *Clan* and *Adhocracy* cultures represent Learning Organizations. Combined *Market* and *Hierarchy* cultures represent Nonlearning Organizations. Highest scores shaded in light grey for each attribute and in dark grey for the highest combined score within each attribute.

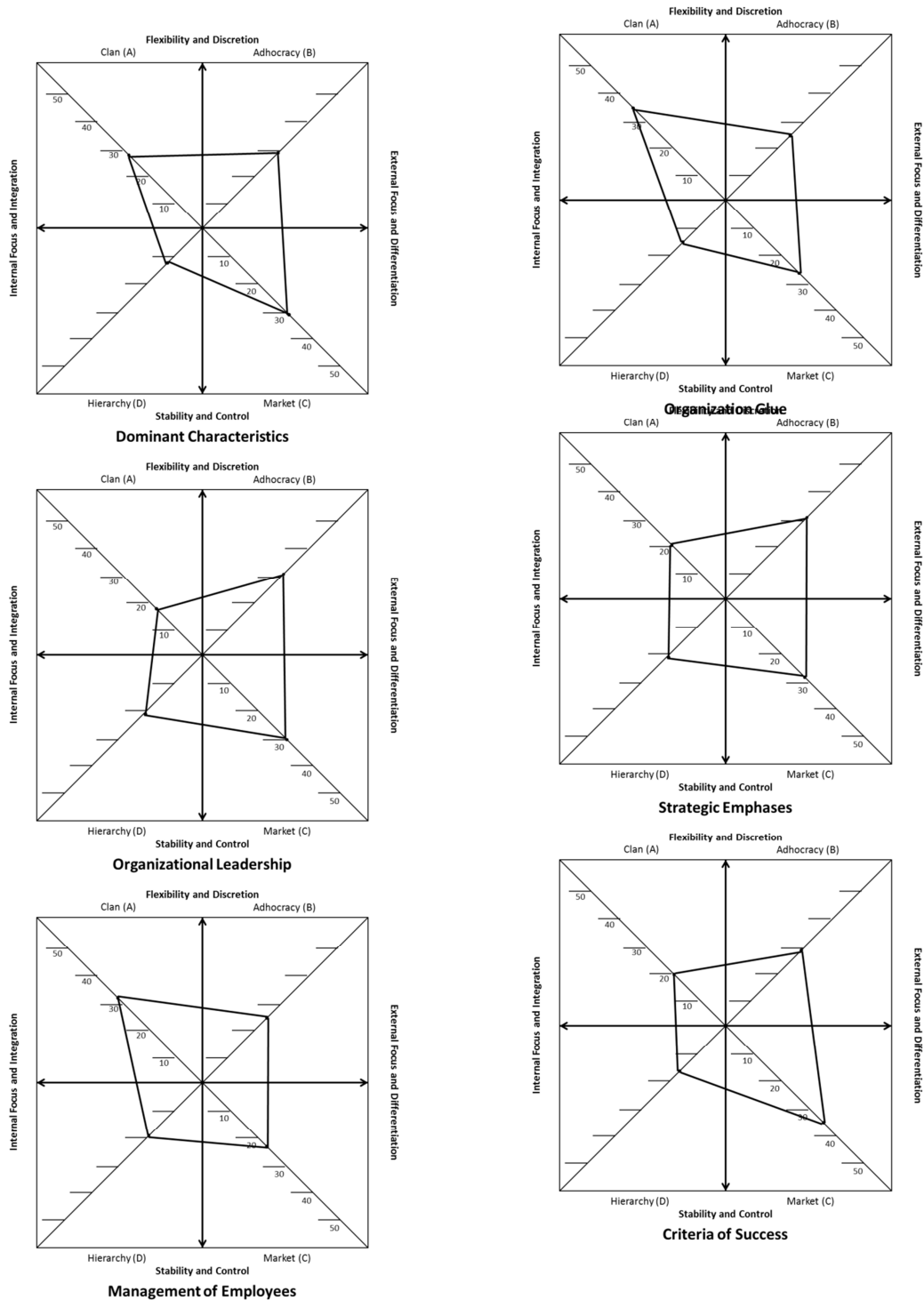


Figure 6. Cultural attribute culture profile for cost management organizations ( $n = 31$ ). From the plot framework in *Diagnosing and Changing Organizational Culture* (p. 76), by K. S. Cameron and R. E. Quinn, 2006, San Francisco, CA: Jossey-Bass. Copyright 2006 by John Wiley & Sons, Inc. Adapted with permission.

**Culture attributes for the Multiple industry segment.** The Multiple industry segment was the second largest group represented in this study. This group demonstrated a more pronounced Nonlearning Organization score (see Table 5) than other industry segments. Whereby the Cost Management Organizations reflected a Learning Organization score of 54, the Multiple segment's Nonlearning Organization score was 54. The Multiple segment represents a variety of industries, which provides an opportunity to explore the dynamics of hybrid organizations. As illustrated in Table 8, Figure 7, and Appendix O, other than for the Management of Employees attribute, the *Market* culture is dominant for all attributes except for Strategic Emphases where there is an equal dominance between the *Clan* and *Market* cultures.

Table 8

*Cultural Attribute Culture Profile for Multiple Segment*

	Clan (A)	Adhocracy (B)	Learning Organization Score	Market (C)	Hierarchy (D)	Nonlearning Organization Score
Dominant Characteristics	26	19	45	32	23	55
Organizational Leadership	21	23	44	30	26	56
Management of Employees	38	14	52	20	28	48
Organization Glue	29	20	49	30	22	52
Strategic Emphases	27	21	48	25	27	52
Criteria of Success	21	21	42	31	27	58

*Note.*  $n = 21$ . Combined *Clan* and *Adhocracy* cultures represent Learning Organizations. Combined *Market* and *Hierarchy* cultures represent Nonlearning Organizations. Highest scores lightly shaded for each attribute and darkly shaded for the highest combined score within each attribute.

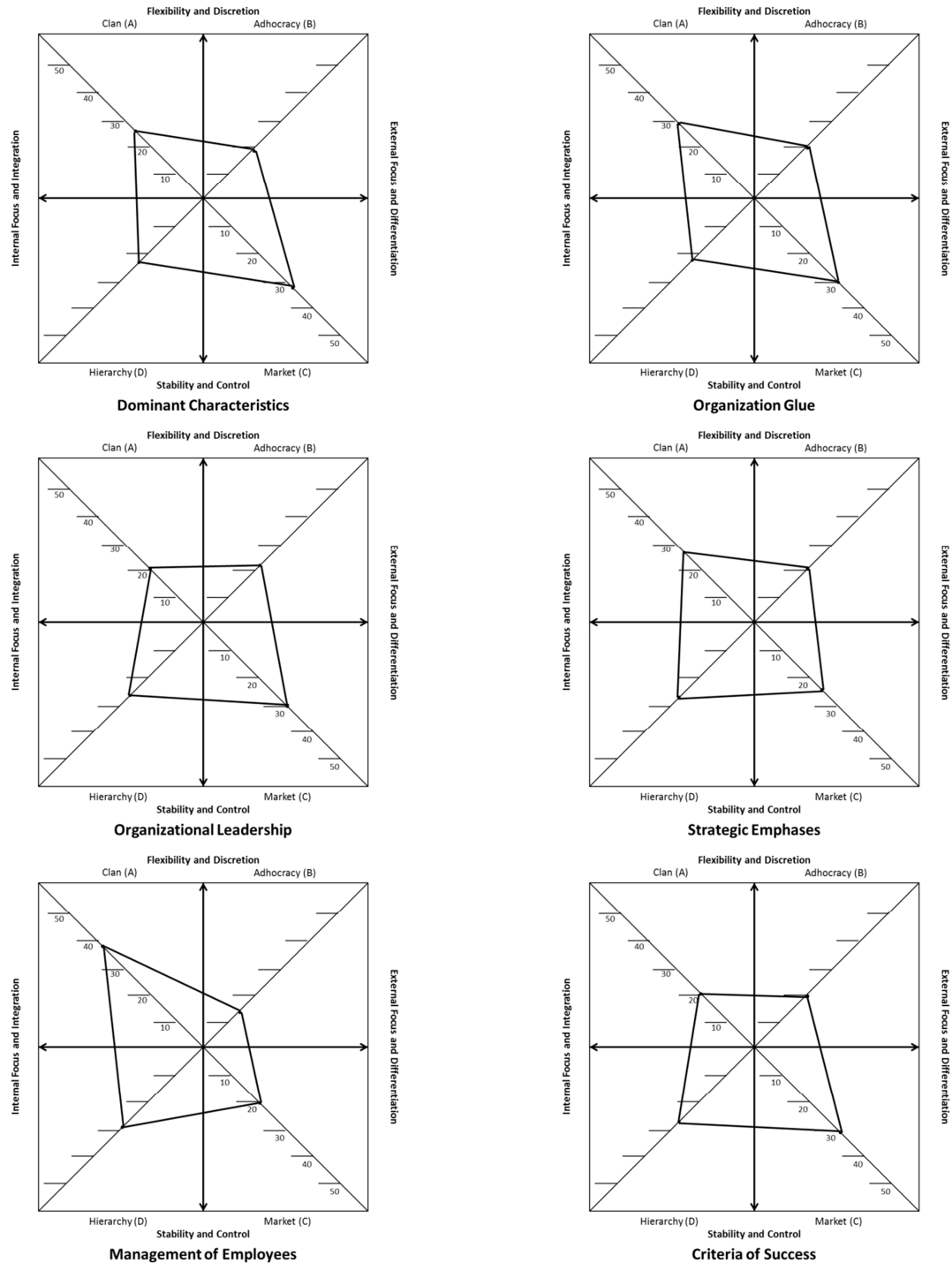


Figure 7. Cultural attribute culture profile for Multiple segment ( $n = 21$ ). From the plot framework in *Diagnosing and Changing Organizational Culture* (p. 76), by K. S. Cameron and R. E. Quinn, 2006, San Francisco, CA: Jossey-Bass. Copyright 2006 by John Wiley & Sons, Inc. Adapted with permission.

The data in Table 8 indicates that this market segment favors a Nonlearning Organization culture. The only attribute reflecting the characteristics of learning organizations is Management of Employees.

### **Key Findings**

A review of the overall health care payment industry culture profile as well as the profiles by core attribute and industry segment indicates the following findings:

1. The health care payment industry does not demonstrate the characteristics of learning organizations (see Table 4).
2. The industry profile is distributed nearly evenly among the four culture types (see Table 2). However, the *Market* culture is slightly more dominant followed closely by the *Clan* culture. The *Hierarchy* culture is least dominant. The *Market* culture focuses on external positioning with a need for stability and control; it is competitive and hard driven. The industry also demonstrates a slight leaning toward the *Clan* culture, which emphasizes internal maintenance with flexibility, concern for people, and sensitivity to customers. This type of culture places a premium on teamwork, participation, and consensus (Cameron & Quinn, 2006). These two cultures are polar opposites, suggesting that different culture profiles apply to various core attributes and/or segments of the industry.
3. For the overall industry, the culture profiles for the six core attributes show differences among core attributes (see Table 3). The profiles for Organizational Leadership and Criteria of Success solidly emphasize the *Market* culture. While the *Market* culture is prevailing for the Dominant

Characteristics and Strategic Emphases attributes, it is also closely aligned with the *Clan* culture in these categories. The attributes for Management of Employees and Organization Glue emphasize the *Clan* culture. The predominance of the *Market* and *Clan* culture profiles in the core attributes help explain the paradox of an industry driven by opposing cultures.

4. Different segments of the health care payment industry demonstrate different culture profiles (see Tables 5 and 6). Consultants, Cost Management Organizations, and companies in the Other category demonstrated a stronger emphasis on the combined *Adhocracy* and *Clan* cultures that include many of the characteristics of learning organizations. Additionally, there was a lower emphasis on the *Hierarchy* culture, which is not supported by learning organizations, in these industry segments. The *Market* culture was clearly dominant for Insurance Companies and IT Vendors. This culture also had the stronger emphasis in the Multiple segment where it was followed closely by the *Clan* culture. TPAs, Employers, PPOs, and organizations in the Multiple segment had stronger *Hierarchy* cultures than did other industry segments.
5. A review of the six culture attributes for the Cost Management and Multiple segment organizations revealed that Cost Management Organizations have a dominant *Market* culture for Dominant Characteristics and Criteria of Success, a dominant *Adhocracy* culture for Organizational Leadership and Strategic Emphases, and a dominant *Clan* culture for Management of Employees and Organizational Glue. This industry segment had dominant Learning Organization scores in four of six attributes (see Table 7). However,



the Multiple segment yielded a very different pattern (see Table 8). For this segment, the *Market* culture dominated in all the attributes categories except for Management of Employees where the *Clan* culture dominated and Strategic Emphases where the *Clan* and *Hierarchy* cultures prevailed. Additionally, the Nonlearning Organization scores dominated five of the six attributes.

### **Summary**

This chapter presented the results of the 106 OCAI survey responses that were captured for this study. As a whole, the industry demonstrated a distributed culture among the four culture profiles. The *Clan* and *Market* cultures showed a slight emphasis with the *Hierarchy* culture being the least dominant. Overall, the industry did not demonstrate a dominant Learning Organization score. However, culture profiles varied among core attributes and industry segments. These patterns reveal that some segments of the industry are better positioned than others as learning organizations and that the attributes of the culture profile provide additional insight into what drives the overall culture of specific industry segments.

## **Chapter 5: Discussion and Conclusions**

Health care continues to present major challenges to policy makers and to the American public, as witnessed by the ongoing political debates, legal battles, and continuous press coverage. Kaplan and Porter (2011), in a study on how to solve the health care cost crisis, report, “U.S. health care costs currently exceed 17% of GDP and continue to rise” (p. 48). Access to care remains a challenge, as demonstrated by the large number of uninsured and underinsured individuals. As baby boomers age, their medical needs are greater, putting yet more pressure on the medical delivery system and further exacerbating costs. Finally, the PPACA, in an effort to address these problems, adds an unprecedented layer of complexity and reporting to the health care payment industry. As a result of these environmental pressures, the health care payment industry must reinvent itself to address effectively these issues. This study explored the culture of the health care payment industry to determine its readiness to adapt to these changes by determining whether the industry’s culture had the characteristics of learning organizations considered best for adapting to revolutionary change.

The results of this study provide health care payment industry leaders with an initial understanding of how well aligned with the characteristics of learning organizations the industry overall and specific segments within the industry are. With this understanding, these individuals can reflect on the culture of their organizations to determine how well positioned they are to adapt to revolutionary changes facing the industry. This study informs organizations that support the health care payment industry on the role of culture in allowing them to meet the complex demands of a health care system on which Americans rely. This new knowledge will allow them to take the

necessary steps to address culture issues and, hence, be better equipped to meet the daunting challenges of the dynamic health care market.

### **Conceptual Foundation**

Experts agree that the rate of change is increasing and that for organizations to succeed, they must adapt to the rapidly changing environment. This condition certainly is evident in the current U.S. health care system. The literature indicates that organizational culture shapes how organizations behave. Learning organizations demonstrate the attributes that increase adaptability to major change. Therefore, for organizations to adapt successfully to change, these entities must have a culture that promotes the characteristics of learning organizations. Learning organizations have structures that promote communication, embrace flexibility, and are less hierarchical. They have strong information system capabilities. Their leaders instill a strong vision and model the desired behavior. These organizations encourage reflection and continual learning. They have cultures that are externally oriented, empowering, have a sense of urgency, promote openness, are more risk tolerant, encourage creativity, and adapt well to change (Cummings & Worley, 2001; Kotter, 1996; Marquardt, 2002; McLagan, 2003; Senge, 2006; Senge et al., 1999).

This study ascertained that the health care payment industry is undergoing change that is outside of the control of the organizations that support this business segment. These dynamics require that the industry redefine its core business and operations to survive. These circumstances constitute revolutionary change (Beckhard & Pritchard, 1992; Burke, 2008; Cummings & Worley, 2001; Kanter et al., 1992; Nadler & Tushman, 1989). The PPACA further complicates the environment in which these organizations

operate. It introduces system dynamics that create changes in certain segments of the industry that ultimately have a ripple effect on other segments. This legislation redefines many of the industry products and processes; mandates universal coverage, driving additional patients into an already stressed system; imposes financial constraints; mandates a higher level of quality and transparency; and promotes price competition. The literature explains that revolutionary change is often triggered by new legislation; the PPACA provides just one more example that this is the case.

When the environment changes, the behaviors that worked well previously may no longer be effective. The old culture blinds the organization to the need for new strategies and the result is a lack of adaptability, resulting in decreasing performance (Kotter & Heskett, 1992). Therefore, culture is recognized as having an important role in whether organizations can transform themselves to meet new market demands. The characteristics of adaptable cultures are speed, creativity, willingness to take risk, open communication, systems thinking, open mental models, flexibility, and nonhierarchical structures. Organizations that demonstrate these characteristics are known as learning organizations. Further supporting the characteristics of learning organizations as enabling change, Reeves and Deimler (2011) propose a model for organizational adaptability that recommends experimentation, a systems approach, and the ability to move quickly.

Senge (2006) summarizes the characteristics of learning organizations into five disciplines. The first is personal mastery, whereby the individuals within the organization are committed to continual personal learning. The second involves exploring mental models that hinder fresh thinking. The third is shared vision, which provides energy and focus. The fourth is team learning, which emphasizes purposeful group interaction

through effective communication. The fifth characteristic is systems thinking, which recognizes interdependency and the need for change. Learning organizations have a culture that facilitates these behaviors and enables the learning necessary to adapt more effectively to environmental demands. The health care payment industry is undergoing revolutionary change, much of which is exacerbated by the PPACA. Organizational culture is critical in allowing organizations to change, and learning organizations are more adaptable. Given these factors, it is critical for organizations in this industry to understand whether they have a culture that will enable them to act as learning organizations that can adapt well to their environment.

### **Study Methods**

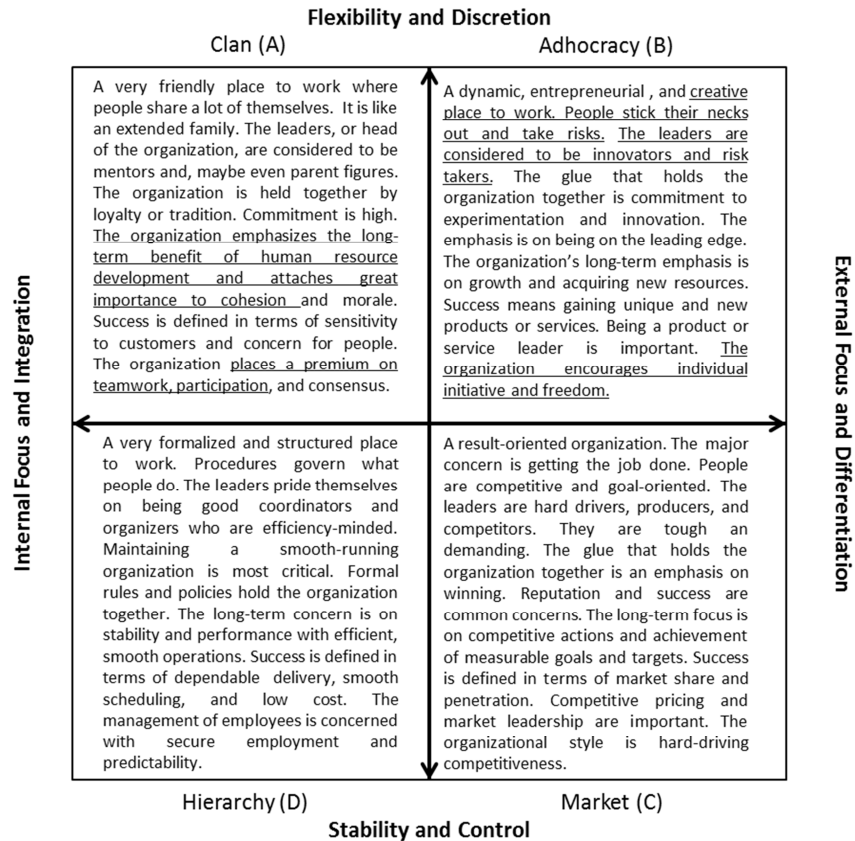
Since culture is the gateway to organizational behavior, it is the determining factor for whether organizations are positioned to nurture the attributes of learning organizations. This study sought to define the current culture of health care payment organizations based on the perception of knowledgeable individuals employed by these types of organizations. Cameron and Quinn (2006) developed the OCAI, which profiles the culture of organizations into four different types. Two of these culture profiles, *Clan* and *Adhocracy*, demonstrate many of the characteristics of learning organizations. Therefore, this instrument was used to obtain the perceptions of a sample of individuals with at least 5 years of industry experience in management or key roles, who are aware of their company culture, and who are currently employed in the industry regarding the culture of their organizations. This survey was web-embedded and did not capture the identity of the respondents or that of the organization for which they work. However, the survey did solicit the industry segment(s) within which the respondents were employed.

A participation e-mail request was sent to 138 individuals employed by 79 organizations, including Insurance Companies, TPA, Self-Insured Employers (Employer), PPO, Health Benefit Consultants (Consultant), Cost Management Organizations, Health Care IT System Vendors (IT Vendor), Other types of organizations supporting the health care payment industry, and those serving Multiple segments of the industry. Three weeks following the launch of the survey, 106 completed responses were received and utilized to tabulate the findings of this study. Table 1 summarizes survey response distribution by industry segments. The Cost Management Organizations (31) had the largest number of responses, followed by the Multiple segments (21).

The survey responses were aggregated using the instructions for scoring the OCAI results. Based this data, the culture profile for the industry, specific industry segments, and each attribute of the culture profile were developed (Cameron & Quinn, 2006).

### **Key Findings**

The OCAI categorizes organizational culture into four profiles (Cameron & Quinn, 2006). The definitions of these four culture profiles are provided in Figure 8, with the characteristics of learning organizations underlined. The underlined characteristics indicate that learning organizations have a *Clan* and/or *Adhocracy* culture profile in which flexibility and discretion are emphasized. Using this model to plot the survey responses, key findings were identified and conclusions developed.



*Figure 8. Culture profile definitions with characteristics of learning organizations underlined. From *Diagnosing and changing organizational culture* (p. 66), by K. S. Cameron and R. E. Quinn, 2006, San Francisco, CA: Jossey-Bass. Copyright 2006 by John Wiley & Sons, Inc. Reprinted with permission.*

Results for the overall industry ( $N = 106$ ) for the six specific attributes that comprise the culture profiles, and for the distinct industry segments, revealed the following:

1. The health care payment industry does not demonstrate a culture profile that is closely aligned with the characteristics of learning organizations. The health care payment industry's culture profile is dominated by the *Clan* and *Market* cultures (see Table 4).

The *Clan* and *Adhocracy* cultures encompass many of the characteristics of learning organizations. Therefore, combining the scores for

these two culture profiles, labeled as Learning Organization score, as compared to the combined scores for the *Market* and *Hierarchy* cultures, labeled as Nonlearning Organization score, provides insight as to how well aligned the industry overall and specific industry segments are with the characteristics of learning organizations. Overall, the industry demonstrates an almost even split between these two combinations. Therefore, it failed to demonstrate a dominant Learning Organization score that would strongly emphasize a combined *Clan* and *Adhocracy* culture reflecting the characteristics of learning organizations. The market segment that scored highest in this combined culture profile was Consultants (see Table 5). This was also the only market segment where an *Adhocracy* culture was dominant.

In addition to Consultants, Cost Management Organizations and organizations in the Other category also had a predominant Learning Organization score. Cameron and Quinn (2006) indicate that a 10-point variance between culture types is noteworthy when assessing discrepancies between culture profiles. The Consultants and companies in the Other category were the only two market segments that showed a greater than 10-point variance between the Learning Organization score and Nonlearning Organization score. Cost Management Organizations had an 8-point spread between these two scores. These results indicate that these three market segments favor a culture that is aligned with the characteristics of learning organizations.

2. The health care payment industry has a distributed culture profile. The overall



industry reflects a distributed culture profile among the four culture types where the *Market* and *Clan* cultures were marginally emphasized. For the overall industry, as summarized in Table 2, the *Market* culture received the highest score (score = 28), followed closely by the *Clan* culture (score = 27). The *Adhocracy* culture ranked third (score = 23) and the *Hierarchy* culture was least dominant (score = 21). These findings suggest the industry is highly competitive, but also guided by a strong paternalistic culture. While no one cultural profile dominates by 10 points or more, the *Adhocracy* culture that drives innovation scored well below the *Market* and *Clan* cultures. The industry overall was not found to emphasize a *Hierarchical* culture.

3. The six culture attribute profiles provide important insight into the constructs of the overall industry profile. The six organizational attributes that comprise the organizational culture profile are summarized in Table 3. The *Market* culture prevailed for Dominant Characteristics, Organizational Leadership, and Criteria of Success. The *Clan* culture was dominant for Management of Employees and Organization Glue. For the Strategic Emphases attribute, the *Clan* and *Market* cultures had matching dominant scores. The *Adhocracy* and *Hierarchy* cultures were not emphasized for any of the attributes.
4. Culture profiles vary by industry segment. A review of the data by industry segment, as summarized in Table 6, reveals that for TPAs, Employers, and PPOs the *Clan* culture prevailed. The *Adhocracy* culture was dominant for Consultants. Cost Management Organizations had the same dominant score for the *Adhocracy* and *Market* cultures. Finally, the *Market* culture was

dominant for Insurance Companies, IT Vendors, and organizations in the Other and Multiple categories. These results indicate that within the health payment industry, specific market segments embrace different cultures. The *Market* and *Clan* cultures were the dominant cultures with the *Adhocracy* culture emerging as strongest in only the Consultant segment. The *Hierarchy* culture did not prevail in any of the segments and scored especially low for Consultants, Cost Management Organizations, and organizations in the Other category. However, this culture profile scored highest in the Multiple segment, which may reflect the complexity of managing multiple functions within one organization.

5. The six attribute profiles vary within specific industry segments. A review of the six attributes used to develop the culture profile of Cost Management Organizations, which represented the largest number of responses (31) and the Multiple segment with the second largest number of responses (21), offers further insight into the attributes that drive the culture of these types of organizations. Cost Management Organizations (see Table 9) scored highest in the *Clan* culture for Management of Employees and Organization Glue. The *Adhocracy* culture was dominant for Organizational Leadership and Strategic Emphases. The *Market* culture prevailed for Dominant Characteristics and Criteria of Success. The dominant scores for each attribute were between 31 and 36. Criteria of Success had the highest score at 36 in the *Market* culture. The *Hierarchy* culture scores were at least 10 points lower for each attribute. This detailed culture profile of the Cost Management

Organization attributes suggests this market segment is highly competitive, values teamwork and innovation, and is not hierarchical. Four of the six attributes fall within the *Clan* and *Adhocracy* culture profiles that reflect many of the characteristics of learning organizations.

Table 9

*Cultural Attribute Culture Profile for Cost Management Organizations*

	Clan (A)	Adhocracy (B)	Market (C)	Hierarchy (D)
Dominant Characteristics	28	29	31	12
Organizational Leadership	17	32	30	21
Management of Employees	32	26	23	18
Organization Glue	34	26	27	14
Strategic Emphases	21	31	28	21
Criteria of Success	20	29	36	15

*Note.*  $n = 31$ . Highest scores shaded within each attribute.

The Multiple segment (see Table 10) demonstrates a very different culture profile. For organizations in this sector, the *Market* culture dominated four of the attributes—Dominant Characteristics, Organizational Leadership, Organization Glue, and Criteria of Success. The *Clan* culture dominated the Management of Employees, and the Strategic Emphases attribute showed matching dominant scores for both the *Clan* and *Hierarchy* cultures. These results tell us that organizations in the Multiple segment are focused on bottom-line results and control. A review of the six attributes indicates that four of the attributes are within the culture profiles of Nonlearning organizations (*Market* and *Hierarchy*); only the Management of Employee attribute was within the Learning

Organization culture profile. The Strategic Emphases was split between the two culture profiles. This culture profile informs us that this industry segment is not well aligned with the characteristics of learning organizations.

Table 10

*Cultural Attribute Culture Profile for Multiple Segment*

	Clan (A)	Adhocracy (B)	Market (C)	Hierarchy (D)
Dominant Characteristics	26	19	32	23
Organizational Leadership	21	23	30	26
Management of Employees	38	14	20	28
Organization Glue	29	20	30	22
Strategic Emphases	27	21	25	27
Criteria of Success	21	21	31	27

*Note.*  $n = 21$ . Highest scores shaded within each attribute.

This study uncovered five key findings. This new data informed the industry on its overall culture as well as that within specific segments of the market. These findings led to conclusions with implications and recommendations for the industry on the need to be better aligned with the characteristics of learning organizations and how to use this information to initiate this process.

## Conclusions

The purpose of this study was to determine the current culture of health care payment organizations to assess for characteristics of learning organizations considered best for adapting to revolutionary change. This information was sought to assist this market segment in promoting characteristics that enable effective change practices. Five

key findings resulted from this research, leading to four conclusions. The conclusions have implications for the industry to consider in using this data to position itself better in adapting to the revolutionary changes within its environment. The first finding, indicating that the industry does not reflect the characteristics of learning organizations and the second finding demonstrating that the industry has a distributed culture profile, were used jointly as the foundation for draw the first conclusion.

**Conclusion 1: As a whole, the health care payment industry's culture is not well positioned to adapt to revolutionary change.** The *Clan* and *Adhocracy* cultures, which encompass the characteristics of learning organizations, are not dominant for the overall industry. Without these characteristics, the industry will have difficulty implementing the strategies needed to adapt to the turbulent environment facing the U.S. health care payment industry.

***Implications of conclusion 1.*** To address better the changes within its environment, the health care payment industry needs to use this information to reorient its culture to align better with the characteristics of learning organizations. While no culture profile dominates the industry, the *Clan* and *Market* cultures received the highest scores. The *Market* culture focuses on market share, profitability, and secure customer bases. This culture values bottom-line results, and is highly competitive and sales driven. It is externally focused on its customers, regulators, essentially, the overall marketplace (Cameron & Quinn, 2006). The industry consists to a large extent of for profit publicly traded organizations and venture capital-backed companies, both of which mandate continued growth in market share, top line revenue, and profitability. The emphasis on the *Market* culture reflects these constant financial pressures. However, given the current

environmental dynamics—escalating costs, the aging population, and the mandates and changes brought forth by PPACA—the industry needs to adopt more of the characteristics of learning organizations found in the *Clan* and *Adhocracy* cultures to continue delivering strong bottom-line results. The *Clan* culture focuses on a collaborative working relationship that promotes teamwork among employees and with clients. Organizations with a dominant *Clan* culture empower their employees and welcome their participation in solving issues and meeting client needs. During times when revolutionary change is present and long-term planning is difficult, this type of culture promotes alignment and effectiveness. The pronounced presence of this culture in the industry demonstrates that some of the attributes of learning organizations already exist, providing a good foundation to develop a more adaptive culture. The *Adhocracy* culture is “an organizational form that is most responsive to...hyperturbulent, ever-accelerating conditions that increasingly typify the organization world” (p. 43). This culture type promotes “adaptability, flexibility, and creativity where uncertainty, ambiguity, and information overload are typical” (p. 44). Additionally, this culture encourages risk taking, high employee involvement, and an eye toward the future. Organizations with an *Adhocracy* culture emphasize growth, new resources, and the development of new products and services to meet the environmental needs. Unfortunately, with the exception of Consultants, this culture profile was not dominant in any other segments of the industry. Given the current market dynamics, the industry should take steps to reduce the dominance of the *Market* culture. To align better with the characteristics of learning organizations, the industry should capitalize on the existing emphasis on the *Clan* culture and develop a greater focus on the *Adhocracy* culture. One

step health care payment organizations can take is to use the OCAI survey within their organizations to ascertain their current versus desired cultures. These results can be used to address the specific needs at the organizational and departmental level to ensure that the organization is positioned to compete successfully by adapting to the dynamic environment in which it operates. While it is important for the industry to adopt more of an *Adhocracy* culture, it cannot fully forfeit the *Market* or *Hierarchy* cultures. In an industry that is getting progressively more regulated, having controls in place to adhere to the mandates is critical. Therefore, some elements of the *Hierarchy* culture must be present. Likewise, competition, which the *Market* culture promotes, must exist to satisfy investors and remain financially viable. However, without the attributes found in the *Adhocracy* and *Clan* cultures, the spirit of competition and winning that drives the industry will not be sustainable in the current volatile environment that requires a greater focus on innovation and flexibility.

**Conclusion 2: While the overall health care payment industry's culture is not well positioned to adapt to revolutionary change, certain segments of the industry—Consultants, Cost Management Organizations, and companies in the Other category—are better situated.** While the overall industry did not demonstrate a Learning Organization culture, there were segments within the industry with culture profiles that were better aligned with those of learning organizations. These findings offer valuable insight to those market segments with cultures that are less adaptable.

***Implications of conclusion 2.*** The market segments that best align with the characteristics of learning organizations offer a model for other industry segments to adopt when attempting to increase their ability to adapt successfully to revolutionary

change. The survey results indicate that Consultants, Cost Management Organizations, as well as companies categorized as Other have higher Learning Organization scores that emphasize a combination of *Clan* and *Adhocracy* cultures than other segments of the industry. Additionally, these three industry segments have lower *Hierarchy* culture scores than organizations in other segments of the market. Since the *Clan* and *Adhocracy* cultures contain many of the characteristics of learning organizations that adapt best to change, these business segments are better positioned to capitalize on opportunities presented by the dynamic health care environment. This knowledge on which market segments best align with the characteristics of learning organizations is not surprising. To counsel effectively their clients, Consultants must carefully scrutinize the environment, understand new mandates, foresee what the future might hold, embrace technology, and develop strategies to help their clients adapt to new conditions. Likewise, Cost Management Organizations are typically niche players who build their business by anticipating and quickly responding to new environmental conditions. They use intellectual knowledge and/or technology to help their clients address the changes. To develop effectively new products that meet emerging market needs, these organizations need to be flexible, closely aligned with the external environment, and highly adaptable. Additionally, these two types of organizations are generally smaller and less likely to be publicly held than insurance companies and TPAs, eliminating some of the factors that add complexity, control, and restrict innovation. The organizations in the Other category include reinsurance and prescription benefit managers. While these appear to have adaptable cultures, the sample is too small and varied to draw any specific conclusions. This study provides empirical evidence regarding which industry segments best



encompass the characteristics of learning organizations. This knowledge provides these organizations as models for the industry to study and partner with in attempting to develop a more adaptable culture. As the industry adjusts to its dramatically changing environment, Insurance Companies, TPAs, PPOs, IT Vendors, and those in the Multiple segment can explore the practices of the more adaptable market segments to begin to understand the culture that drives these organizations. As mergers, acquisitions, and strategic alliances are considered, the less adaptable organizations should seek to partner with organizations in the market segments that demonstrate the characteristics of learning organizations. This coupling will allow these organizations to learn from the practices of their more adaptable partners. They should be careful to preserve the culture of the more adaptable organizations in hopes that this culture will gradually permeate the overall enterprise, resulting in an overall enterprise that is more adaptable and better able to respond quickly and effectively to fast-changing environmental demands.

**Conclusion 3: The health care payment industry is competitive, goal oriented, and driven by financial results.** Within the six attributes that comprise the industry's culture profile, *Market* culture is prevalent in three of the six categories—Dominant Characteristics, Organizational Leadership, and Criteria of Success. Additionally, the *Market* culture and *Clan* cultures are tied as dominant for the Strategic Emphases attribute. These results indicate that the attributes of the *Market* culture influence the behavior of the industry to a larger extent than the characteristics of other culture types.

***Implications of conclusion 3.*** The *Market* culture does not align well with the characteristics of learning organizations. Therefore, the emphasis on this culture is not

ideal for an industry undergoing revolutionary change. The culture attributes where the *Market* culture prevails influence the overall industry culture profile as follows:

1. Dominant Characteristics reflect what the overall organization is like,
  2. Organizational Leadership reveals the leadership style and approach that drive the organization,
  3. Criteria of Success governs how success is defined and what gets rewarded, and
  4. Strategic Emphases defines the areas that drive the organization's strategy
- (Cameron & Quinn, 2006).

Organizations seeking to move their culture toward one that further emphasizes the *Adhocracy* and *Clan* cultures should first look at how they operate in the four domains where the *Market* culture is emphasized. Learning organizations have leaders with strong visions that set the tone for their team. The leaders are intimately involved in developing the corporate strategy and compensation systems. Therefore, if the health care payment industry wants to move its culture, this move needs to start with the leadership of the organizations that comprise this market. These individuals are best positioned to initiate the changes needed to promote adaptability. Using the insight provided by this study, industry leaders can reflect on their organizations' current cultures and determine whether the norms and values that have served them well in the past are the same ones that will drive their success in the future. Reeves and Deimler (2011), in their article offering a model for adaptability, warn that in an unpredictable environment, traditional approaches no longer apply. Culture is the gateway to change and without a clear understanding of their organizations' present cultural state, the leaders of health care

payment organizations will waste precious time, energy, and resources mandating changes that their organizations are ill equipped to deliver.

While the *Market* culture dominated four of the attributes, it is important to note that the *Clan* culture was prevalent in two of the attributes—Management of Employees and Organization Glue—and tied as dominant with the *Market* culture for Strategic Emphases. The different culture profiles within the six attributes explain the factors that result in the paradox of an industry culture profile that almost equally emphasizes the *Market* and *Clan* cultures. This lack of consistency in the dominant culture within the six attributes creates a potential challenge to execution of organizational strategies. In this instance, the data suggests the leadership is driven by a highly competitive agenda where the focus is on getting the job done while the workforce is more focused on teamwork and consensus. These findings suggest that for the overall industry, the workforce does not fully embrace the competitive focus. As organizations explore their cultures to align it with the characteristics of learning organizations, they will also need to identify cultural patterns that could indicate conflicting orientations. Industry leaders will need to provide a vision that aligns all members of their organizations to embrace the new direction they are proposing. Insight into the culture profiles for each of the attributes will allow leaders to prioritize the areas that require a culture shift to enable change. It will also allow these individuals to target cultures attributes that are inconsistent within the organization. An example within the overall industry is that the attribute for Criteria of Success has a dominant *Market* culture. However, the *Clan* culture dominates the Management of Employees attribute. This information suggests that while the industry is driven by financial results, employee incentives and compensation are based on teamwork and

longevity instead of bottom-line contributions. Culture is an important element of organizational success, which, in the current environment, is predicated on the ability to adapt. The more details leaders of health care payment organizations have about the culture that drives the behaviors of their organizations, the better they can deliver results.

**Conclusion 4: Organizational culture is complex and requires in-depth analysis to understand better.** The six attributes that constitute the culture profiles provide further insight into the culture profiles of the various business segments. This additional knowledge, as it pertains to Cost Management Organizations, provides a better understanding of the elements of learning organizations.

***Implications of conclusion 4.*** The attribute culture profiles of Cost Management Organizations, which represented the largest number of participants in the study, provides other market segments with valuable information on the constructs of a Learning Organization culture. The culture profile of the Cost Management Organizations indicates this market segment is better positioned as a learning organization than the rest of the industry. The Learning Organization scores are dominant for Dominant Characteristics, Management of Employees, Organization Glue, and Strategic Emphases. While the Nonlearning Organization scores prevail for Organizational Leadership and Criteria of Success, they are minimally more dominant. The attributes for Organizational Leadership and Strategic Emphases are both dominated by the *Adhocracy* culture, which indicates that the organizational leadership encourages innovation, prudent risk taking, and flexibility. Where the *Market* culture prevails—Dominant Characteristics and Criteria of Success—it appropriately keeps this market segment focused on the need to remain competitive, but not at the risk of paralyzing the organization’s ability to respond

to market needs. It is also interesting to note that the *Hierarchy* culture scores for this industry segment are low overall and at least 9 points below the dominant culture within each attribute. Hierarchies are not consistent with learning organizations and the attribute profiles of Cost Management Organizations further support this premise. The culture attribute profile of this industry segment presented in this study offers a roadmap for the rest of the industry to follow as it seeks to align its culture with that of learning organizations. Leaders within the less adaptable segments of the industry can compare the attribute profiles within their organizations to those of the Cost Management Organizations. Where discrepancies exist, they can use that data to address culture shifts needed within the organizations to align them with learning organization characteristics.

Cameron and Quinn (2006) advise, “One reason it is useful to know your organization’s culture type is because organizational success depends on the extent to which your organization’s culture matches the demands of the competitive environment” (p. 71). The literature stipulates that the health care payment industry is in the midst of tremendous turmoil. This study provides new information on the culture of the overall industry and some of the segments that comprise it. These findings provide a gateway for the industry to understand how its present culture can enhance or hinder its ability to address the current environmental challenges. This study also offers ideas of how the industry and its leaders can use the findings of this study to begin understanding and building an organizational culture that will better adapt to revolutionary change.

### **Limitations of the Study**

The high level of participation (77%) in this study indicated that the web-based OCAI survey was an appropriate tool for this study. It also reflected a high level of

interest in the research topic. Every effort was made to assure the validity of this study by using a well-recognized and empirically tested survey instrument as well as taking the necessary steps to assure the integrity of the captured data. Nonetheless, the study does present the following limitations:

1. The health care payment industry is composed of thousands of organizations that employ hundreds of thousands of employees. This study is based on the perceptions of 106 individuals employed by approximately 79 different organizations within various segments of the industry. Because the targeted population was abstract, whether these individuals' views are representative of the industry segment as a whole are not known. Therefore, this study provides only a single snapshot of the health care payment industry.
2. Organizational culture is complex and difficult to ascertain. Schein (2000) stipulates that fully understanding culture requires more than a questionnaire. He suggests interviews and observation of the organization are indicated. Therefore, it is important to recognize that the culture profiles developed in this study are superficial and based on the perceptions of the survey respondents. These perceptions do not provide an in-depth cultural picture of the industry.

### **Recommendations**

Regardless of the limitations of this study, the findings that emerged from this research contribute to the existing body of knowledge and provide opportunities for further research.

**Contributions to the body of knowledge.** Cameron and Quinn (2006), in their research of thousands of organizations, compiled a culture profile for the Finance, Insurance, Real Estate industry. While that industry segment does not fully align with organizations in the health care payment industry, it is interesting to note that the profile closely mirrors the one developed in this study. This finding suggests that the results of this study are consistent with culture profiles for like organizations resulting from prior research and as such added to the existing body of knowledge within a similar industry segment. However, no prior studies focusing on the health care payment industry's culture and adaptability were identified. Therefore, the findings from this research provide fresh insight regarding the culture of the industry and specific segments within it. This data inform us on the industry's alignment with the characteristics of learning organizations that best adapt to revolutionary change and better positions leaders of health care payment organizations to address the challenges they face in adapting to the turbulent external environment. Additionally, when this study was initiated, the PPACA was newly enacted. The theoretical foundation on change associated with this research along with the PPACA requirements inform the industry that this legislation constitutes revolutionary change and that the industry needs to prepare for its impact. This study also validated that the OCAI in a web-embedded format is a robust tool for conducting an initial assessment of organizational culture in this market segment. The construct of this research, whereby a culture assessment instrument instead of a learning organization questionnaire is used to diagnose whether an organization is well positioned as a learning organization, offers a new model that recognizes that culture is the foundation for organizational behavior. The lack of empirical studies within the health care payment

industry as well as pertaining to the coupling of organizational culture, learning organizations, and adaptability suggests that this area of research is open for exploration.

**Proposed new studies.** This study offers fresh knowledge and also lays the foundation for additional research. There is a need for in-depth and more comprehensive studies on culture within this specific market segment and for specific organizations within this health care payment system industry. There is also an opportunity to conduct more comprehensive longitudinal studies to ascertain which culture profile yielded the best results in adapting to the post PPACA market pressures. This study indicates that leaders will need to drive culture change. Therefore, the role of leadership in influencing the culture profile of health care payment organizations is another potential area of study. Finally, the approach for this study could be applied to other industries undergoing revolutionary change.

### **Closing Comments**

As the United States continues to search for a well-balanced solution to its health care challenges, it is incumbent upon all the parties in the industry to help find the answers that will resolve the cost, quality, and access issues challenging our health care system. Washington has spoken and the industry needs to respond in a manner that will make a positive difference to the future of the American health care system. The industry's best chance at finding the right answers is to learn from the past and creatively embrace the future with the spirit of learning organizations. This study alerts the industry that it lacks the characteristics of learning organizations and that it will have difficulty adapting to the revolutionary changes it faces. However, beyond providing valuable information on the current positioning of the industry, this study also offers an approach



for addressing these changes as well as a deeper understanding of what drives the current culture. The industry can use the findings from this study as a stepping-stone for organizations to use in assuring they are well positioned for their new world. Donald Berwick (as cited in Atlantic Information Services, 2010), who for several years until November 2011 was responsible for the government CMS programs, indicated that in the current turbulent environment, preserving the status quo will not be constructive. By providing an initial snapshot of the culture of the industry, this study suggests that unless this culture becomes more aligned with that of learning organizations, it will be difficult for the industry to move forward. It also informs us that certain segments and, hence, certain organizations will do well in this dynamic setting, providing a good model for other segments of the industry. The 2010 annual reports for Cigna and Aetna, two major organizations in the health care payment industry, acknowledged the revolutionary pace of change in the industry and the need to adapt. This study reveals that culture is a critical component to allowing organizations to adapt; without the characteristics of learning organizations, new strategies will be difficult to implement. When the statement was made during the opening session of the American Health Insurance Plan Annual Forum in 2010 that organizations within the industry would need to change their culture to adjust to health care reform, no empirical evidence to support that statement was provided. This study provides the needed substance for this message to get the attention of the industry.

The support I received from colleagues in the health care payment industry as I launched this research project indicated there was interest in better understanding how well positioned the industry was to adapt successfully to the major changes it faces. This search for knowledge is a positive indication industry leaders recognize that they need

help navigating this new environment. This willingness to consider and contribute to new content indicates they may be disposed to reconsider their existing mental models. This mind-set is a key characteristics of learning organizations and a good indicator that there are many in the industry who are ready to explore new solutions to help solve the U.S. health care crisis.

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## APPENDIX A

### Legislative Provisions

Component	Provisions
Quality, affordable health care for all Americans	Expands benefit coverage by extending coverage, eliminating pre-existing provisions and out-of-pocket limitations, mandating certain preventative care benefits, simplifying benefit coverage information, mandating ratios on expenditure of medical versus administrative expenses. Creates health exchanges to provide affordable coverage to individuals and small employers.
The role of public programs	Expands public insurance programs and under some circumstances reduces payments to medical providers
Improving the quality and efficiency of health care	Links Medicare payments to providers to quality. Establishes accountable health plans with quality based reimbursement that offer an alternative to commercial insurance plans. Revises Medicare pharmacy benefit reimbursement. Looks at accuracy of payment to ancillary medical providers.
Prevention of chronic disease and improving public health	Provision of preventive care in government sponsored plans
Health care workforce	Provides funding for education of health care workers in primary areas of care
Transparency and program integrity	Requires public information on health systems and measures to combat fraud & abuse
Improving access to innovative medical therapies	Reduces costs to patients for certain biological and pharmaceutical products
Community living assistance services and support	Establishes a voluntary long term care insurance program.
Revenue provisions	Provide funding for PPACA through taxing of insurance companies and administrators for high cost plans. Other provisions for reporting and incremental fees for insurers and medical providers and manufacturers of pharmaceuticals and medical devices.
Universal coverage	Mandated coverage for most Americans.

House Committees on Ways and Means, Energy and Commerce, and Education and Labor, 2010, p. 1

## APPENDIX B

### Permission for Use of the OCAI

From: [REDACTED]  
Sent: Friday, March 25, 2011 11:11 AM  
To: Hunt, Susan (student)  
Subject: FW: Doctoral Student Permission Request Follow-Up

Dear Ms. Hunt:

John Wiley & Sons, Inc. has no objection with the use as outlined below. Credit must appear on every copy using the material and must include the title; the author (s); and/or editor (s); Copyright (year and owner); and the statement "Reprinted with permission of John Wiley & Sons, Inc."

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Sincerely,

[\[cid:image001.gif@01CBEAF6.0D3320A0\]](#)

[REDACTED] Permissions Coordinator  
Phone: [REDACTED] Fax: [REDACTED] Email: [REDACTED] John Wiley & Sons, Inc. | 111 River Street |  
Hoboken, NJ | 07030

---

**From:** [REDACTED]  
**Date:** Fri, 1 Apr 2011 15:24:44 -0400  
**To:** [REDACTED] >  
**Subject:** your permission request

Dear Ms. Hunt,

I am happy to grant permission to republish the content you requested.

Best wishes,

[REDACTED]

---

[REDACTED] - Coordinator, Global Rights - John Wiley & Sons, Inc.  
111 River St., MS 4-02 - Hoboken, NJ 07030-5774  
[REDACTED]



*Think Green - Please consider business costs and the environment before you print this email!*

[REDACTED]

---

From: [REDACTED] on behalf of Permissions - US  
Sent: Monday, March 14, 2011 9:10 AM  
To: [REDACTED]  
Subject: FW: Republication/Electronic Request Form

Categories: Permissions

Hi [REDACTED]

Thesis request.

Thanks,

[REDACTED]  
Associate Manager, Permissions  
Global Rights  
John Wiley & Sons, Inc.  
ph: [REDACTED]  
f: [REDACTED]  
[REDACTED]

-----Original Message-----

From: [PermissionsUS@wiley.com](mailto:PermissionsUS@wiley.com) on [www.wiley.com](http://www.wiley.com) [<mailto:webmaster@wiley.com>]  
Sent: Saturday, March 12, 2011 1:02 PM  
To: Permissions - US  
Subject: Republication/Electronic Request Form

A01\_First\_Name: Susan  
A02\_Last\_Name: Hunt  
A03\_Company\_Name: Pepperdine University  
A04\_Address: [REDACTED]  
A05\_City: [REDACTED]  
A06\_State: [REDACTED]  
A07\_Zip: [REDACTED]  
A08\_Country: USA  
A09\_Contact\_Phone\_Number: [REDACTED]  
A10\_Fax: [REDACTED]  
A11\_Emails: [REDACTED]  
A12\_Reference:  
A13\_Book\_Title: Diagnosing and Changing Organizational Culture  
A40\_Book\_or\_Journal: Book  
A14\_Book\_Author: Kim S. Cameron  
A15\_Book\_ISBN: 978-0-7879-8283-6 & 0-7879-8283-0  
A16\_Journal\_Month:  
A17\_Journal\_Year:  
A18\_Journal\_Volume:  
A19\_Journal\_Issue\_Number:  
A20\_Copy\_Pages: Figure 2.1  
A21\_Maximum\_Copies: None  
A22\_Your\_Publisher: Dissertation - Pepperdine University  
A23\_Your\_Title: Doctoral Dissertation  
A24\_Publication\_Date: Q4 2011  
A25\_Format: WW

PERMISSION GRANTED

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A41\_Ebook\_Reader\_Type:  
 A26\_If\_WWW\_URL: To be determined  
 A27\_If\_WWW\_From\_Adopted\_Book:  
 A28\_If\_WWW\_Password\_Access: Yes  
 A45\_WWW\_Users: ~350  
 A29\_If\_WWW\_Material\_Posted\_From: Estimate 7/1/11  
 A30\_If\_WWW\_Material\_Posted\_To: Estimate 9/15/11  
 A42\_If\_Intranet\_URL:  
 A32\_If\_Intranet\_From\_Adopted\_Book:  
 A33\_If\_Intranet\_Password\_Access:  
 A48\_Intranet\_Users:  
 A34\_If\_Intranet\_Material\_Posted\_From:  
 A35\_If\_Intranet\_Material\_Posted\_To:  
 A50\_If\_Software\_Print\_Type:  
 A60\_If\_Other\_Type:  
 A37\_Comments\_For\_Request: I am a student at Pepperdine University in Malibu, California, where I am pursuing a doctorate in organizational change. My dissertation research focuses on determining whether health care organizations have a culture that is adaptable to major change. Considering the recent health care reform legislation and the associated changes that are sweeping the industry, it is important for health care organizations to adapt well to this new environment in order to remain viable. This study will provide a baseline to allow the leaders of these organizations to assess whether they need to revisit the culture of their organizations to allow this to happen.

The OCAI categorizes the survey responses into four major culture types. One of these is the adhocracy culture which indicates the organization adapts well to major change. I would like to use a modified version of the OCAI to survey management level individuals in health care organizations and determine if the results demonstrate that, in general, these individuals' responses indicate their organizations reflect an adhocracy culture. If the findings show that the majority of responses fall within this category, it would provide a good indication that, generally, the industry will adapt well to health care reform or other major change; if not, the organizational leaders will need to consider how to shift the culture within their organizations to become more adaptable.

For purposes of my study, I propose to modify the OCAI in three ways:

- Only ask the survey participants to respond to the "Now" category as I am only interested in determining the current culture within these organizations;
- Create a web-embedded electronic survey to capture survey participants' responses. This mode of delivery is cost effective, and since the survey participants all have access to computers, provides an effective means of soliciting maximum participation. Please note that responses will be anonymous to protect the identity of the respondents, and
- The respondents will be asked to identify the type (not name) of organization they work for. This information will be used to determine if responses vary significantly based on the industry segment of the respondent.

As a student, I am trying to identify the best method for my research while also keeping the costs at a minimum. Therefore, I would appreciate your permission to use the modified version of the OCAI free of charge. Upon completion of the study, I would gladly share my aggregated findings with you. It is also worth mentioning that this study will bring to the attention of the survey participants, many of which are executives within health care organizations, the importance of culture in managing change and the availability of your tool to help them in this critical measure. Therefore, my study may help promote use of your book by the survey participants and within their organizations.

I appreciate your consideration of this request and look forward to hearing back from you in the near future. Should you have any questions, please contact me at [REDACTED] or at [REDACTED].

Sincerely,

Susan Hunt



## APPENDIX C

### The Organizational Culture Assessment Instrument

#### 1. *Dominant Characteristics*

*Score*

A. The organization is a very personal place. It is like an extended family. People seem to share a lot of themselves.	
B. The organization is a very dynamic and entrepreneurial place. People are willing to stick their necks out and take risk.	
C. The organization is very results-oriented. A major concern is with getting the job done. People are very competitive and achievement-oriented.	
D. The organization is a very controlled and structured place. Formal procedures generally govern what people do.	
Total	100

#### 2. *Organizational Leadership*

*Score*

A. The leadership in the organization is generally considered to exemplify mentoring, facilitating, or nurturing.	
B. The leadership in the organization is generally considered to exemplify entrepreneurship, innovation, or risk taking.	
C. The leadership in the organization is generally considered to exemplify a no-nonsense, aggressive, results-oriented focus.	
D. The leadership in the organization is generally considered to exemplify coordinating, organizing, or smooth-running efficiency.	
Total	100

#### 3. *Management of Employees*

*Score*

A. The management style in the organization is characterized by teamwork, consensus, and participation.	
B. The management style in the organization is characterized by individual risk taking, innovation, freedom, and uniqueness.	
C. The management style in the organization is characterized by hard-driving competitiveness, high demands, and achievement.	
D. The management style in the organization is characterized by security of employment, conformity, predictability, and stability in relationships.	
Total	100

#### 4. *Organization Glue*

*Score*

A. The glue that holds the organization together is loyalty and mutual trust. Commitment to this organization runs high.	
B. The glue that holds the organization together is commitment to innovation and development. There is an emphasis on being on the cutting edge.	
C. The glue that holds the organization together is the emphasis on achievement and goal accomplishment.	
D. The glue that holds the organization together is formal rules and policies. Maintaining a smooth-running organization is important.	
Total	100

#### 5. *Strategic Emphases*

*Score*

A. The organization emphasizes human development. High trust, openness, and participation persist.	
B. The organization emphasizes acquiring new resources and creating new challenges. Trying new things and prospecting for opportunities are valued.	
C. The organization emphasizes competitive actions and achievements. Hitting stretch targets and winning in the marketplace are dominant.	
D. The organization emphasizes permanence and stability. Efficiency, control, and smooth operations are important.	
Total	100

#### 6. *Criteria of Success*

*Score*

A. The organization defines success on the basis of the development of human resources, teamwork, employee commitment, and concern for people.	
B. The organization defines success on the basis of having the most unique or newest products. It is a product leader and innovator.	
C. The organization defines success on the basis of winning in the marketplace and outpacing the competition. Competitive market leadership is key.	
D. The organization defines success on the basis of efficiency. Dependable delivery, smooth scheduling, and low-cost production are critical.	
Total	100

*Note.* From OCAI survey in *Diagnosing and changing organizational culture* (p. 26), by K. S. Cameron and R. E. Quinn, 2006, San Francisco, CA: Jossey-Bass. Copyright 2006 by John Wiley & Sons, Inc. Reprinted with permission.

## APPENDIX D

### Survey Participation Request

As a knowledgeable and respected colleague in the industry, I am seeking your assistance with my doctoral dissertation research. I am a student at Pepperdine University pursuing a doctoral degree in Organizational Change. My dissertation chair is Dr. Kay Davis. The purpose of this study is to determine whether health care payment system organizations, such as yours, demonstrate the culture of learning organizations that adapt best to revolutionary change.

I am asking a number of professionals in our industry to anonymously complete a web survey version of The Organizational Culture Assessment Instrument (OCAI) published by Kim S. Cameron and Robert E. Quinn in their book titled *Diagnosing and Changing Organizational Culture*. It will take you approximately **10 minutes** to complete the survey. This survey is structured to keep both your identity and that of your organization anonymous. The survey host website will not track your e-mail or IP address. These safeguards were taken so there would be minimal risk to you in taking the survey. In the unlikely event that your identity is revealed, the identifying information will be immediately deleted. Additionally, the study is designed in such a way that the published results will not reflect the identity of respondents or their organizations even if it were available.

Experts agree that the rate of change in our environment is increasing and that organizations must adapt more quickly and effectively to survive and thrive in these turbulent times. If the results of this study indicate respondents perceive the culture of their organizations as demonstrating characteristics of adaptable organizations, we can expect the health care payment industry to handle major environmental changes such as health care reform effectively.

Participation in this research study is voluntary. However, I value your insight and certainly would appreciate your response. To access the survey select the following link: [REDACTED]. Please complete the survey by **September 12<sup>th</sup>**.

Upon completion of my research, I will forward the summary findings to the individuals who were invited to participate. I hope you will find the results of this study interesting and of assistance in planning for future major changes your organization may undergo. If you know of any colleagues in management or key staff functions working in the types of organizations identified within the survey instrument, who would be interested in participating in this study, please forward this e-mail to them. The greater the level of participation, the more meaningful the findings will be. Please contact me at [REDACTED] or at [REDACTED] with any questions.

Thank you for considering this request to bring new insight to our industry.

Sincerely,

Susan Hunt

Doctoral Candidate

## APPENDIX E

### Instructions for Completing the Organization Culture Assessment Instrument

The survey you are being asked to complete is an anonymous survey. Therefore, your email and IP address associated with your survey response are not maintained and are not visible to the administrator of this survey. To further protect the anonymity of survey respondents, once a survey is set to anonymous it cannot be changed to a non-anonymous survey.

For my doctoral dissertation I am researching whether health payment system organizations demonstrate the culture of learning organizations that adapt best to revolutionary change. For purposes of this study, I am using the Organizational Culture Assessment Instrument (OCAI).

The OCAI consists of six items. Each item has four alternatives. Divide 100 points among these four alternatives, depending on the extent to which each alternative is similar to your own organization. For example, on item 1, if you think alternative A is very similar to your organization, alternatives B and C are somewhat similar, and alternative D is hardly similar at all, you might give 55 points to A, 20 points each to B and C, and 5 points to D. Just be sure your total equals 100 for each item. For your convenience the web based survey tool will add up your answers in each section to assure they total 100 points.

To assist in determining any significant variances between different types of health care payment organizations, please indicate below the type(s) of organization(s) that best describe the organization you currently work for and on which your responses to the survey will be based. Select all that apply:

Insurance company

Third party administrator

Self-insured employer

Health benefits consultant

Preferred provider organization

Cost management organization

Health care IT systems vendor

Other (please describe but do not give the name of the organization)

Note: The Organizational Culture Assessment Instrument which the survey participants completed can be found in Cameron and Quinn (2006) p. 26.


## APPENDIX F

### Institutional Review Board Clearance

# PEPPERDINE UNIVERSITY

## Graduate & Professional Schools Institutional Review Board

August 18, 2011

Susan Hunt  


Protocol #: E0811D02

Project Title: *A Quantitative Study of the Culture of Health Care Payment Organizations as Learning Organizations Able to Adapt to Revolutionary Change*

Dear Ms. Hunt:

Thank you for submitting your application, *A Quantitative Study of the Culture of Health Care Payment Organizations as Learning Organizations Able to Adapt to Revolutionary Change*, for exempt review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your faculty advisor, Dr. Kay Davis, have done on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations (45 CFR 46 - <http://www.nihtraining.com/ohsr/site/guidelines/45cfr46.html>) that govern the protections of human subjects. Specifically, section 45 CFR 46.101(b)(2) states:

(b) Unless otherwise required by Department or Agency heads, research activities in which the only involvement of human subjects will be in one or more of the following categories are exempt from this policy:

**Category (2) of 45 CFR 46.101**, research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: a) Information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and b) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

In addition, your application to waive documentation of consent, as indicated in your

**Application for Waiver or Alteration of Informed Consent Procedures** form has been approved.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit a **Request for Modification Form** to the GPS IRB. Because your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the GPS IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the

6100 Center Drive, Los Angeles, California 90045 • 310-568-5600

*Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual*  
(see link to "policy material" at <http://www.pepperdine.edu/irb/graduate/>).

Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact me. On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

Sincerely,

[Redacted Signature]

[Redacted Name]

Manager, GPS IRB & Dissertation Support  
Pepperdine University  
Graduate School of Education & Psychology

[Redacted Contact Information]

W:  
F:

cc:

[Redacted Distribution List]

## APPENDIX G

### Pilot Study Participation Request

In follow-up to our conversation, I want to thank you for your willingness to help test the web-based survey I will be using to gather data for my doctoral dissertation.

As a reminder, I am a student at Pepperdine University pursuing a doctoral degree in organization change. My dissertation chair is Dr. Kay Davis. The purpose of my dissertation research is to obtain the perception of professionals in the health payment system industry on whether this business segment demonstrates the culture of learning organizations that adapt best to revolutionary change. In view of the changes the industry is undergoing, I hope this study will provide insight to leaders of these types of organizations regarding how well positioned the industry is to address the volatile environment we operate in and provide some ideas on what needs to be considered to succeed in these challenging times.

To protect the anonymity of survey participants, the web embedded survey I am using does not track the identity of the respondent or the organization with which the respondent is affiliated.

As discussed, I would appreciate your assistance in testing the survey tool by:

- ☐ Reviewing the attached assessment form ***prior to proceeding*** with the survey, testing the areas noted on the form, and providing your feedback using this form
- ☐ Accessing the survey using the link provided in a follow up e-mail entitled “test participation request” and providing feedback on ease of use, clarity of instructions, and the length of time it took you to complete the survey
- ☐ Returning the completed assessment form to me at [REDACTED]

Your input will allow me to optimize the survey tool prior to disseminating it to the target participants. Your help in improving this process will help promote participation.

If you have any questions, please contact me at [REDACTED] or [REDACTED].

Your assistance and professional opinion are appreciated. Thank you for your interest, support, and participation.

Sincerely,

Susan Hunt

Doctoral Candidate



## APPENDIX H

### Pilot Study Assessment Form

#### Web Survey

Did you have any trouble accessing the survey?

Yes \_\_\_\_ (please explain) \_\_\_\_\_

No \_\_\_\_

Did you have any trouble completing the survey?

Yes \_\_\_\_ (please explain) \_\_\_\_\_

No \_\_\_\_

Were you able to take the survey more than once from the same computer?

Yes \_\_\_\_ (please explain) \_\_\_\_\_

No \_\_\_\_

Did the survey allow you to enter responses that did not total 100 for each section and continue with the survey?

Yes \_\_\_\_ (please explain where & what happened) \_\_\_\_\_

No \_\_\_\_

How long did it take you to complete the survey? \_\_\_\_\_

Were you able to stop taking the survey mid-course and then resume later on?

Yes \_\_\_\_

No \_\_\_\_ (please explain what happened) \_\_\_\_\_

Additional comments regarding the survey:

---

---

---

#### **Survey Instructions**

Were the instructions easy to follow?

Yes \_\_\_\_

No \_\_\_\_ (please provide suggestions for improvement)

---

---

---

Surveyor Name: \_\_\_\_\_

Date: \_\_\_\_\_

## APPENDIX I

### Survey Participation Follow-Up Request

I am following-up on my request for participation in my dissertation research. Thank you to all of you who have already completed the survey. The original participation request and survey link are provided below for those of you who have not yet had an opportunity to respond and are interested in doing so. I would appreciate if you could complete the survey by **September 19<sup>th</sup>**.

Thank you for your help.

**From:** Susan Hunt

**Sent:** Saturday, August 27, 2011 3:59 PM

**Subject:** Survey - Health Care Culture & Adaptability

As a knowledgeable and respected colleague in the industry, I am seeking your assistance with my doctoral dissertation research. I am a student at Pepperdine University pursuing a doctoral degree in Organizational Change. My dissertation chair is Dr. Kay Davis. The purpose of this study is to determine whether health care payment system organizations, such as yours, demonstrate the culture of learning organizations that adapt best to revolutionary change.

I am asking a number of professionals in our industry to anonymously complete a web survey version of The Organizational Culture Assessment Instrument (OCAI) published by Kim S. Cameron and Robert E. Quinn in their book titled *Diagnosing and Changing Organizational Culture*. It will take you approximately **10 minutes** to complete the survey. This survey is structured to keep both your identity and that of your organization anonymous. The survey host website will not track your e-mail or IP address. These safeguards were taken so there would be minimal risk to you in taking the survey. In the unlikely event that your identity is revealed, the identifying information will be immediately deleted. Additionally, the study is designed in such a way that the published results will not reflect the identity of respondents or their organizations even if it were available.

Experts agree that the rate of change in our environment is increasing and that organizations must adapt more quickly and effectively to survive and thrive in these turbulent times. If the results of this study indicate respondents perceive the culture of their organizations as demonstrating characteristics of adaptable organizations, we can expect the health care payment industry to handle major environmental changes such as health care reform effectively.

Participation in this research study is voluntary. However, I value your insight and certainly would appreciate your response. To access the survey select the following link: [REDACTED]. Please complete the survey by **September 12<sup>th</sup>**.

Upon completion of my research, I will forward the summary findings to the individuals who were invited to participate. I hope you will find the results of this study interesting and of assistance in planning for future major changes your organization may undergo.

If you know of any colleagues in management or key staff functions working in the types of organizations identified within the survey instrument, who would be interested in participating in this study, please forward this e-mail to them. The greater the level of participation, the more meaningful the findings will be.

Please contact me at [REDACTED] or at [REDACTED] with any questions.

Thank you for considering this request to bring new insight to our industry.

Sincerely,

Susan Hunt

Doctoral Candidate

# APPENDIX J

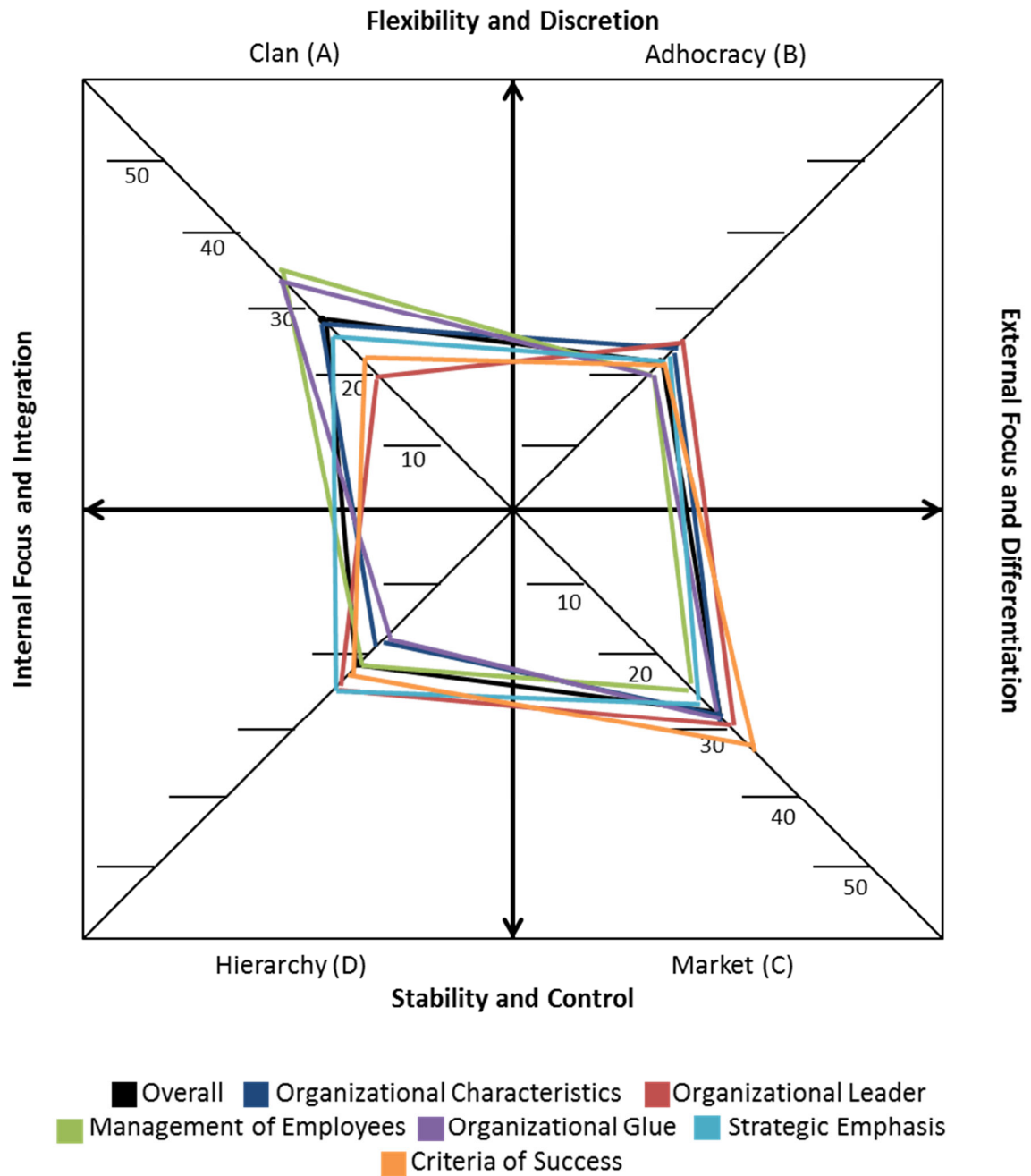
## Organization Types Categorized in the Multiple Segment ( $n = 21$ )

Organization Types				
PPO	Cost Management Organization			
Health Benefit Consultant	PPO	Cost Management Organization	Health Care IT Systems Vendor	
TPA	Employer	PPO	Cost Management Organization	
Insurance Company	TPA	Employer	Cost Management Organization	
PPO	Cost Management Organization			
Insurance Company	TPA			
Insurance Company	TPA	Employer		
PPO	Cost Management Organization			
Insurance Company	TPA	Employer		
PPO	Cost Management Organization			
Insurance Company	TPA	Employer		
TPA	PPO	Cost Management Organization		
PPO	Cost Management Organization			
TPA	Health Benefits Consultant			
PPO	Cost Management Organization			

Organization Types				
TPA	PPO	Cost Management Organization		
Insurance Company	TPA	Employer	PPO	Cost Management Organization
Insurance Company	Employer	Integrated Delivery System		
Insurance Company	TPA	Employer	Integrated Health Care Organization	
TPA	PPO	Cost Management Organization		
Cost Management Organization	Technology based Healthcare Finance Company			

## APPENDIX K

### Culture Profile of the Total Sample by Culture Attribute



*Note.* From the plot framework in *Diagnosing and Changing Organizational Culture* (p. 76), by K. S. Cameron and R. E. Quinn, 2006, San Francisco, CA: Jossey-Bass. Copyright 2006 by John Wiley & Sons, Inc. Adapted with permission.

# APPENDIX L

## Health Care Payment Industry Survey Responses for the Overall Industry and by Industry

Segment (N = 106)

### Health Care Payment Industry Survey Responses for the Overall Industry and by Industry Segment

Category	Overall n = 106	Insurance Company n = 10	TPA n = 11	Self-insured employer n = 5	Health benefits consultant n = 6	PPO n = 14	Cost Mgmt Org n = 31	Health care IT systems vendor n = 4	Other n = 4	Multiple n = 21
<i>1. Dominant Characteristics</i>										
A. The organization is a very personal place. It is like an extended family. People seem to share a lot of themselves.	28	24	28	40	31	28	28	39	28	26
B. The organization is very dynamic and entrepreneurial. People are willing to stick their necks out and take risks.	25	25	25	20	38	21	29	16	35	19
C. The organization is very results-oriented. A major concern is getting the job done. People are very competitive and achievement-oriented.	29	26	26	24	22	30	31	28	25	32
D. The organization is a very controlled and structured place. Formal procedures generally govern what people do.	18	26	22	16	10	21	12	18	13	23
Total	100	100	100	100	100	100	100	100	100	100

Category	Overall n = 106	Insurance Company n = 10	TPA n = 11	Self-insured employer n = 5	Health benefits consultant n = 6	PPO n = 14	Cost Mgmt Org n = 31	Health care IT systems vendor n = 4	Other n = 4	Multiple n = 21
<i>2. Organizational Leadership</i>										
A. The leadership in the organization is generally considered to exemplify mentoring, facilitating, or nurturing	20	27	23	20	23	18	17	15	28	21
B. The leadership in the organization is generally considered to exemplify entrepreneurship, innovation, or risk taking.	27	28	27	18	33	20	32	19	33	23
C. The leadership in the organization is generally considered to exemplify a no-nonsense, aggressive, results-oriented focus.	30	33	29	29	27	27	30	44	21	30
D. The leadership in the organization is generally considered to exemplify coordinating, organizing, or smooth-running efficiency,	23	13	21	33	17	35	21	23	19	26
Total	100	100	100	100	100	100	100	100	100	100
<i>3. Management of Employees</i>										
A. The management style in the organization is characterized by teamwork, consensus, and participation.	34	31	28	40	23	36	32	35	41	38



Category	Overall n = 106	Insurance Company n = 10	TPA n = 11	Self-insured employer n = 5	Health benefits consultant n = 6	PPO n = 14	Cost Mgmt Org n = 31	Health care IT systems vendor n = 4	Other n = 4	Multiple n = 21
B. The management style in the organization is characterized by individual risk taking, innovation, freedom, and uniqueness.	21	22	21	15	36	18	26	16	28	14
C. The management style in the organization is characterized by hard-driving competitiveness, high demands, and achievement.	24	30	28	18	27	23	23	28	21	20
D. The management style in the organization is characterized by security of employment, conformity, predictability, and stability in relationships.	21	18	23	27	14	23	18	21	10	28
Total	100	100	100	100	100	100	100	100	100	100
<i>4. Organization Glue</i>										
A. The glue that holds the organization together is loyalty and mutual trust. Commitment to this organization runs high.	34	39	35	45	33	40	34	25	35	29
B. The glue that holds the organization together is commitment to innovation and development. There is an emphasis on being on the cutting edge.	21	14	17	17	37	12	26	23	29	20

Category	Overall <i>n</i> = 106	Insurance Company <i>n</i> = 10	TPA <i>n</i> = 11	Self-insured employer <i>n</i> = 5	Health benefits consultant <i>n</i> = 6	PPO <i>n</i> = 14	Cost Mgmt Org <i>n</i> = 31	Health care IT systems vendor <i>n</i> = 4	Other <i>n</i> = 4	Multiple <i>n</i> = 21
C. The glue that holds the organization together is the emphasis on achievement and goal accomplishment.	28	24	31	24	22	31	27	40	29	30
D. The glue that holds the organization together is formal rules and policies. Maintaining a smooth-running organization is important.	17	23	17	14	9	18	14	13	8	22
Total	100	100	100	100	100	100	100	100	100	100
<i>5. Strategic Emphases</i>										
A. The organization emphasizes human development. High trust, openness, and participation persist.	26	22	28	29	22	33	21	39	30	26
B. The organization emphasizes acquiring new resources and creating new challenges. Trying new things and prospecting for opportunities are valued.	24	20	18	22	32	19	31	11	26	24
C. The organization emphasizes competitive actions and achievement. Hitting stretch targets and winning in the	26	34	23	24	30	24	28	21	31	26

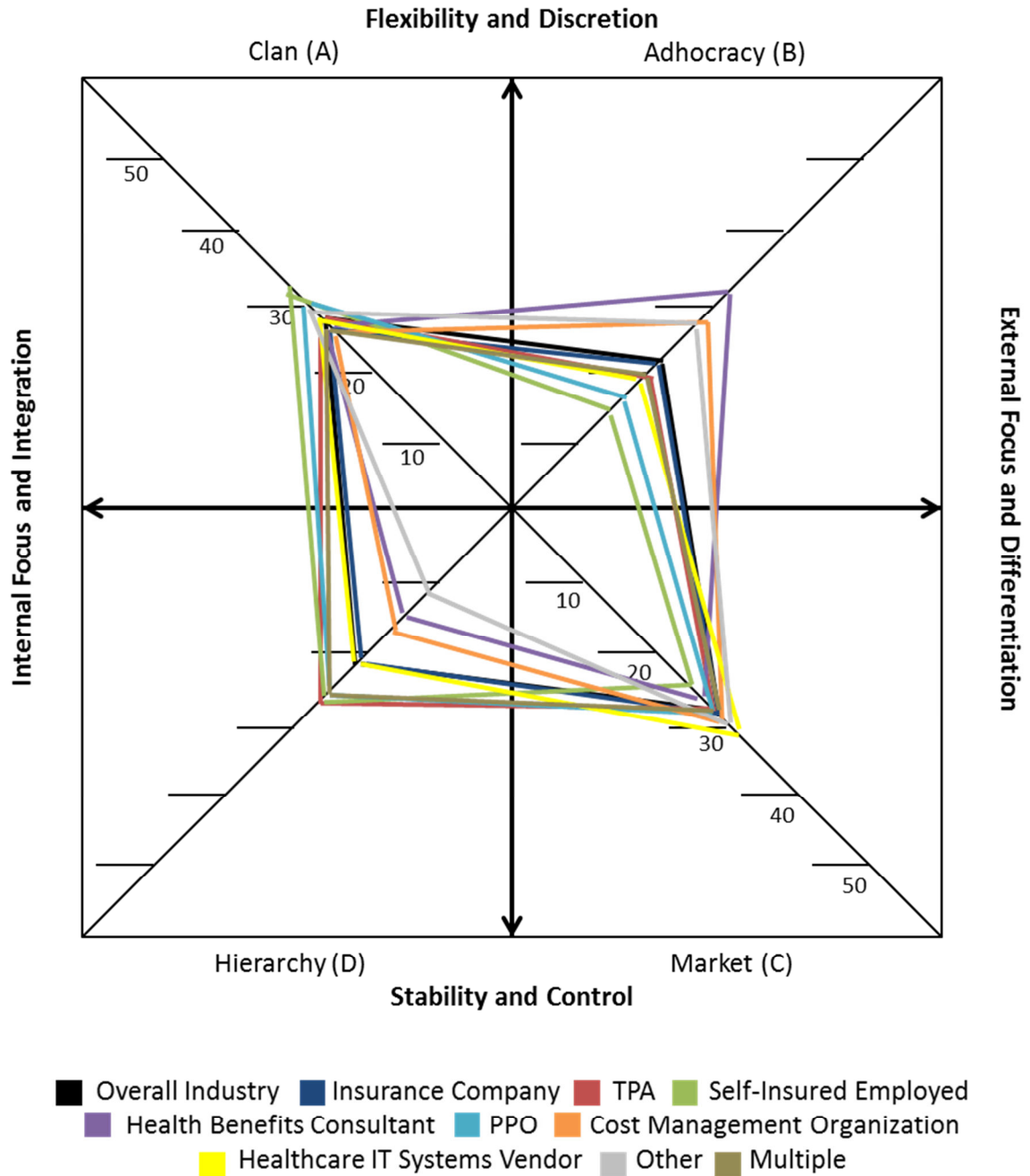
Category	Overall n = 106	Insurance Company n = 10	TPA n = 11	Self-insured employer n = 5	Health benefits consultant n = 6	PPO n = 14	Cost Mgmt Org n = 31	Health care IT systems vendor n = 4	Other n = 4	Multiple n = 21
marketplace are dominant.										
D. The organization emphasizes permanence and stability. Efficiency, control, and smooth operations are important.	24	26	31	25	16	24	21	29	13	24
Total	100	100	100	100	100	100	100	100	100	100
<i>6. Criteria of Success</i>										
A. The organization defines success on the basis of the development of human resources, teamwork, employee commitment, and concern for people.	22	17	27	25	27	28	20	16	18	22
B. The organization defines success on the basis of having the most unique or newest products. It is a product leader and innovator.	22	30	14	12	22	15	29	30	17	22
C. The organization defines success on the basis of winning in the marketplace and outpacing the competition. Competitive market leadership is key.	33	33	28	27	38	31	36	28	56	33
D. The organization defines success	22	21	31	36	14	25	15	26	10	22

Category	Overall <i>n</i> = 106	Insurance Company <i>n</i> = 10	TPA <i>n</i> = 11	Self-insured employer <i>n</i> = 5	Health benefits consultant <i>n</i> = 6	PPO <i>n</i> = 14	Cost Mgmt Org <i>n</i> = 31	Health care IT systems vendor <i>n</i> = 4	Other <i>n</i> = 4	Multiple <i>n</i> = 21
on the basis of efficiency. Dependable delivery, smooth scheduling, and low-cost production are critical.										
Total	100	100	100	100	100	100	100	100	100	100

*Note.* *N* = 106

## APPENDIX M

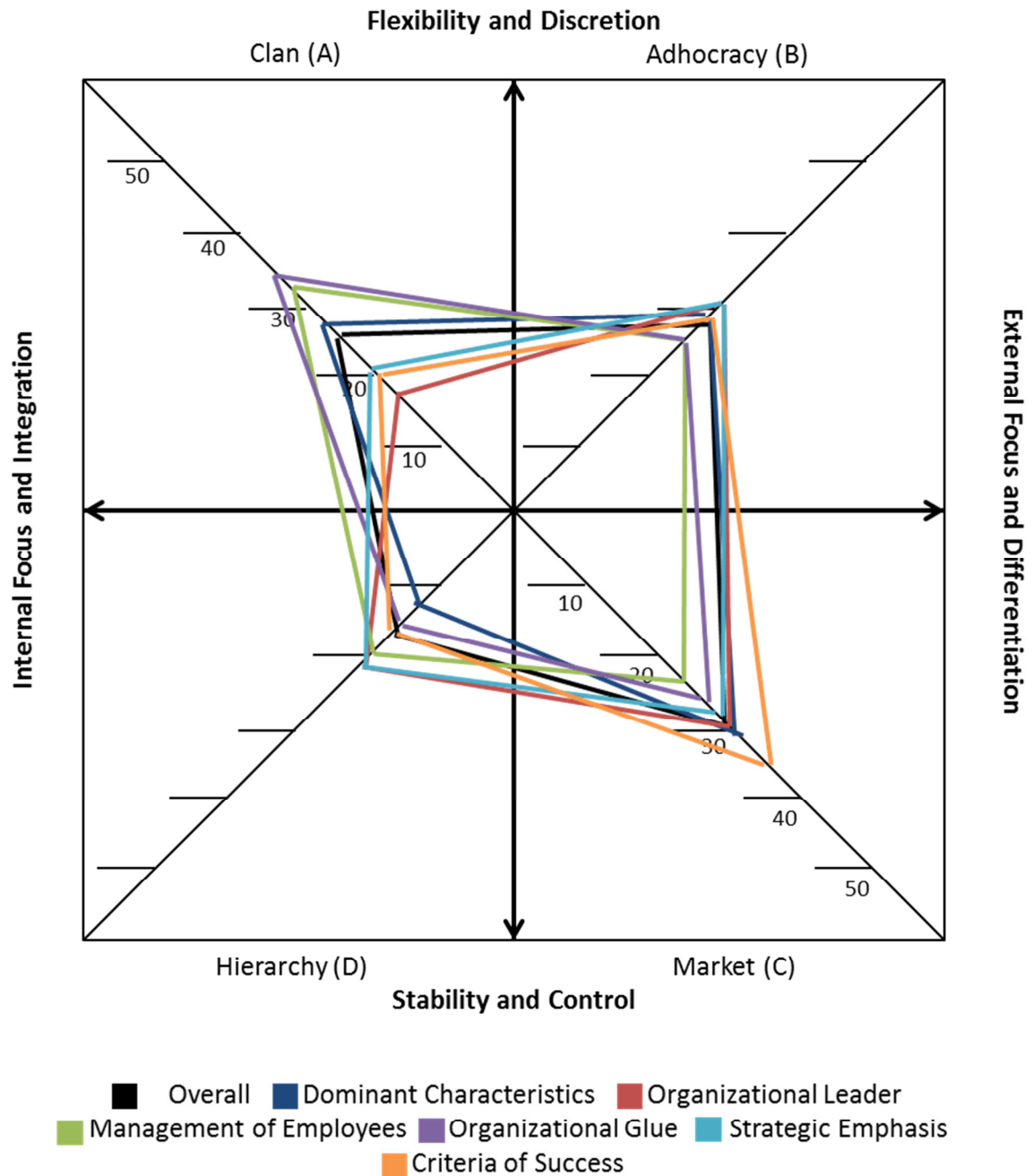
### Culture Profile of Participants' Organizations by Industry Segment



*Note.* From the plot framework in *Diagnosing and Changing Organizational Culture* (p. 77), by K. S. Cameron and R. E. Quinn, 2006, San Francisco, CA: Jossey-Bass. Copyright 2006 by John Wiley & Sons, Inc. Adapted with permission.

## APPENDIX N

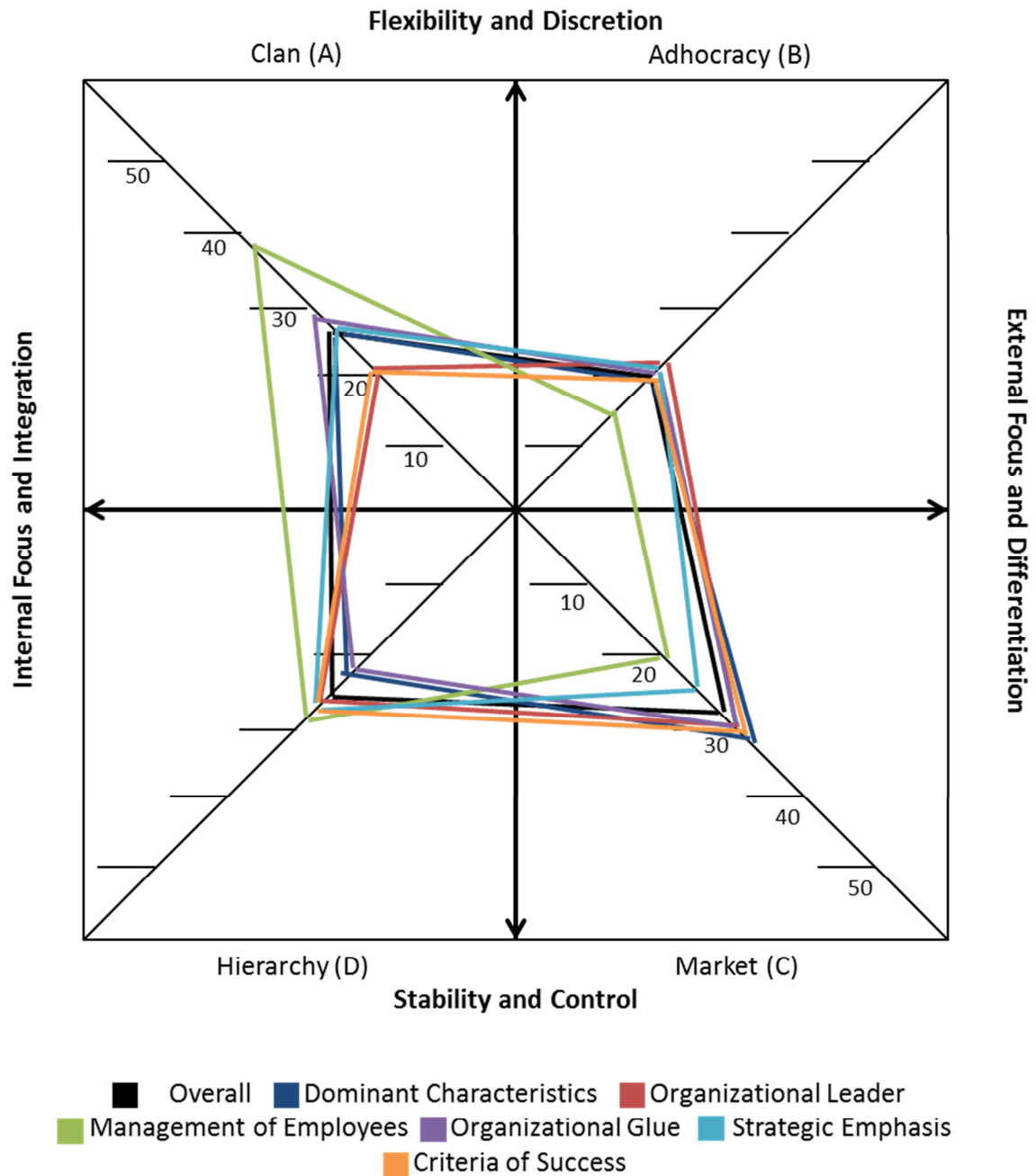
### Culture Profile Attributes of Cost Management Organizations



*Note.* From the plot framework in *Diagnosing and Changing Organizational Culture* (p. 76), by K. S. Cameron and R. E. Quinn, 2006, San Francisco, CA: Jossey-Bass. Copyright 2006 by John Wiley & Sons, Inc. Adapted with permission.

## APPENDIX O

### Culture Profile Attributes of Organizations in the Multiple Industry Segment



*Note.* From *Diagnosing and changing organizational culture* (p. 76), by K. S. Cameron and R. E. Quinn, 2006, San Francisco, CA: Jossey-Bass. Copyright 2006 by John Wiley & Sons, Inc. Adapted with permission.